Health Canada
Santé Canada

Canada Health Act

Annual Report 2003-2004

Canada

"Our mission is to help the people of Canada maintain and improve their health."

Health Canada

Ce document est également disponible en français sous le titre :
Loi canadienne sur la santé – Rapport annuel 2003-2004

Prepared by:
Health Canada
Health Policy Branch
Canada Health Act Division

To contact the Canada Health Act Division:
Visit our website at: **http://www.hc-sc.gc.ca/medicare**
E-mail us at: **medicare_hc@hc-sc.gc.ca**
Write to us at:
Canada Health Act Division
0908C Brooke Claxton Building
Tunney's Pasture
Ottawa, ON K1A 0K9
Canada

For additional copies of this publication, please contact the Health Canada Publications Centre:
Health Canada Publications Centre
0900C2 Tunney's Pasture
Ottawa, ON K1A 0K9
Canada

Telephone: (613) 954-5995
Fax: (613) 941-5366
E-mail: publications@hc-sc.gc.ca

This document is also available on the Health Canada website at:
http://www.hc-sc.gc.ca/medicare

To contact provincial and territorial health departments, please see contact information inside the back cover.

This publication may be provided in alternate formats upon request.

© Her Majesty the Queen in Right of Canada, 2005.

Canada Health Act Annual Report 2003-2004.
Cat.H1-4/2004E
ISBN0-662-37707-9
Publication No. 1230

105-04474/

Minister of Health
Ministre de la Santé

The Honourable/L'honorable Ujjal Dosanjh
Ottawa, Canada K1A 0K9

December, 2004

Her Excellency, the Right Honourable Adrienne Clarkson,
Governor General and Commander-in-Chief of Canada

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year that ended March 31, 2004.

Ujjal Dosanjh

Canada

Preface

In presenting this year's Annual Report on the *Canada Health Act*, I do so in the context of a year in which great progress has been made in securing a strong and dynamic health care system for Canadians.

On September 16, 2004, all First Ministers came together to reach an historic agreement – a Ten-Year Plan to Strengthen Health Care. This Plan crosses party lines and transcends provincial boundaries. It constitutes a truly national response to a national priority and puts us firmly on the road to sustainable health care for many years to come.

The Action Plan reaffirms a commitment to the principles of the *Canada Health Act*: public administration, comprehensiveness, universality, portability and accessibility. This commitment was more than just a formality – it was a firm endorsement of the publicly funded health care system on which Canadians rely and in which they strongly believe.

By reasserting that access to medically necessary insured services should be based on need, not on one's ability to pay, all First Ministers sent a very clear message that this country has no intention of developing one health care system for the wealthy and another for everyone else.

The Action Plan also committed all parties to work together, across jurisdictions, across the country. By emphasizing collaboration among all governments, the First Ministers made clear their intention to work together for a common purpose; to fight *for* medicare, not *over* medicare.

With this Action Plan came new funding from the Government of Canada – some $41 billion over the next 10 years to meet the funding recommendations of the Romanow Report and to make timely access to quality care a reality for all Canadians.

Canada's health care system is a reflection of the values we hold as a nation and of the commitment we have made to one another as citizens.

By providing access to health services through a single-payer system, Canadians have made a conscious and deliberate decision to make health care a basic right for all, not just a privilege for the few. This collective choice is formally embodied in the *Canada Health Act*.

April 17, 2004, marked the 20th anniversary of the *Canada Health Act*. Since its unanimous passage by Parliament in 1984, this Act has served as the Charter of Medicare, safeguarding key principles while providing the provinces with the flexibility they need to innovate and pursue their own priorities. It has served us well and remains an important touchstone of shared values.

While all governments have the responsibility to honour the principles of the *Canada Health Act*, it falls to the federal government to ensure that those principles are respected. As Minister of Health, I have an obligation to uphold the law and I will work to ensure that the benefits of medicare are available to all Canadians.

Any time individuals can pay for quicker access to medically necessary hospital or physician services, or may be required to pay to access these services, represents a threat to the fundamental principles of the *Canada Health Act*. Access to insured health services in our publicly financed health care system must be based on need, not on the ability to pay.

As can be seen in Chapter 2 of this Report, there are some outstanding issues with respect to provincial compliance. For example, full insurance coverage for all medically necessary services performed in clinics in some jurisdictions is not available. While this and other issues remain of concern, I am confident that resolution can be reached.

When such issues arise, my preferred approach is to try and work things out with the province or territory involved in a spirit of goodwill and openness. Disputes may be addressed through the *Canada Health Act* dispute avoidance and resolution process which was agreed to in 2002, and recently formalized by First Ministers in September 2004. This process provides for either party to refer an issue to an independent panel of experts to review the matter and make recommendations.

While it remains the responsibility of the Minister of Health to uphold and enforce the Act, I believe that involving unbiased experts where there is disagreement over interpretation makes the application of the Act much more transparent and impartial.

As Minister, I am satisfied that, for the most part, provincial and territorial health insurance plans meet the criteria and conditions of the *Canada Health Act*. I look forward to working with all of my colleagues to strengthen a health care system which defines us as a great nation.

Ujjal Dosanjh
Minister of Health

Acknowledgements

Health Canada would like to acknowledge the work and effort that went into producing this Annual Report. It is through the dedication and timely commitment of the following departments of health and their staff that we are able to bring you this report on the administration and operation of the *Canada Health Act*:

Newfoundland and Labrador Department of Health and Community Services
Prince Edward Island Health and Social Services
Nova Scotia Department of Health
New Brunswick Department of Health and Wellness
Quebec Department of Health and Social Services
Ontario Ministry of Health and Long-Term Care
Manitoba Health
Saskatchewan Health
Alberta Health and Wellness
British Columbia Ministry of Health Services
Yukon Department of Health and Social Services
Northwest Territories Department of Health and Social Services
Nunavut Department of Health and Social Services

We also greatly appreciate the extensive work effort that was put into this report by our production team: the desktop publishing unit, the translators, editors and concordance experts, and staff of Health Canada at headquarters and in the regional offices.

Table of Contents

Preface . . . iii

Acknowledgements . . . v

Introduction . . . 1

Chapter 1 – Canada Health Act Overview . . . 3

Chapter 2 – Administration and Compliance . . . 9

Chapter 3 – Provincial and Territorial Health Care Insurance Plans in 2003-2004 . . . 23

- Newfoundland and Labrador . . . 27
- Prince Edward Island . . . 43
- Nova Scotia . . . 59
- New Brunswick . . . 75
- Quebec . . . 93
- Ontario . . . 99
- Manitoba . . . 115
- Saskatchewan . . . 133
- Alberta . . . 155
- British Columbia . . . 165
- Yukon . . . 187
- Northwest Territories . . . 207
- Nunavut . . . 219

Annex A – Canada Health Act and Extra-Billing and User Charges Information Regulations . . . 231

Annex B – Policy Interpretation Letters . . . 255

Annex C – Dispute Avoidance and Resolution Process under the Canada Health Act . . . 265

Annex D – Documents Related to the Canadian Health Care System . . . 271

Annex E – Glossary of Terms Used in the Annual Report . . . 281

How to Contact Provincial and Territorial Departments of Health . . . inside back cover

Introduction

The five principles of the *Canada Health Act* are the cornerstone of the Canadian health care system, and reflect the values that inspired Canada's single-payer, publicly-financed health care system. This legislation, passed unanimously by Parliament in 1984, affirms the federal government's commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis. The *Canada Health Act* defines for the provinces and territories the criteria and conditions that they must satisfy in order to qualify for their full share of the federal transfers under the Canada Health and Social Transfer (CHST) cash contribution (effective April 1, 2004, the cash contribution became payable under the Canada Health Transfer).

This report is produced in accordance with the requirement set out in section 23 of the *Canada Health Act*:

> "The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria , and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed."

Under the *Canada Health Act*, the federal Minister of Health is required to provide information on the operation of provincial and territorial health care plans as they relate to the criteria and conditions of the Act. The approach to this information gathering has been collaborative, where provinces, territories and the federal government have worked together to supply the information needed by the Minister.

Chapter 1 provides an overview of the *Canada Health Act* and the associated regulations and policies that are used in the administration of the Act. Chapter 2 reviews the administration of the *Canada Health Act* during 2003-2004, and includes a summary of compliance issues addressed and deductions levied. It also describes the evolution of federal transfers for health care in Canada. Chapter 3 presents descriptions of the provincial and territorial health insurance plans, including statistical data on insured hospital, physician and surgical-dental health care services. The annexes to this report provide additional information relevant to the administration of the Act and its place in the Canadian health care system.

Annex A is an office consolidation of the *Canada Health Act* and its regulations (unofficial version dated June 2001). Annex B presents the text of two key policy statements that clarify the federal interpretation of the criteria and conditions of the *Canada Health Act*. Annex C provides a description of the Canada Health Act Dispute Avoidance and Resolution process which came into effect in 2002. Annex D provides references to documents that support information found in provincial and territorial narratives. Annex E is a glossary of terminology used in this report. Inside the back cover you will find contact information for provincial and territorial departments of health.

Chapter 1 – Canada Health Act Overview

> *"The principles of the Canada Health Act began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians."*
>
> *(Roy J. Romanow, Q.C., November, 2002)*

In this chapter, the *Canada Health Act*, its requirements and key definitions under the Act are discussed. Also described are the regulations and regulatory provisions of the *Canada Health Act* and the interpretation letters by former federal Ministers of Health Jake Epp and Diane Marleau to their provincial and territorial counterparts that are used in the interpretation and application of the Act.

What is the Canada Health Act?

The *Canada Health Act* (CHA or the Act) is Canada's federal legislation for publicly funded health care insurance.

The Act sets out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The CHA establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must fulfill to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).

The aim of the CHA is to ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service for such services.

Key Definitions under the CHA

Insured persons are eligible residents of a province or territory. A resident of a province is defined in the CHA as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Persons excluded under the CHA include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

Insured health services are medically necessary hospital, physician and surgical-dental services provided to insured persons.

Insured hospital services are defined under the CHA and include medically necessary in- and out- patient services such as accommodation and meals at the standard or public ward level and preferred accommodation if medically required; nursing service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; medical and surgical equipment and supplies; use of radiotherapy facilities; use of physiotherapy facilities; and services provided by persons who receive remuneration therefore from the hospital, but does not include services that are excluded by the regulations.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Extended health care services as defined in the CHA are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Requirements of the Canada Health Act

The *Canada Health Act* (CHA or the Act) contains the following nine requirements that the provinces and territories must fulfill to qualify for the full federal cash contributions:

- ☐ five program criteria that apply only to insured health services;
- ☐ two conditions that apply to insured health services and extended health care services; and
- ☐ extra-billing and user charge provisions that apply only to insured health services.

The Criteria

1. Public Administration (section 8 of CHA)

   The public administration criterion, set out in section 8 of the CHA, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans are administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision making on benefit levels and services, and whose records and accounts are publicly audited.

2. Comprehensiveness (section 9)

   The comprehensiveness criterion of the CHA requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists (i.e., surgical-dental services which require a hospital setting) and, where the law of the province so permits, similar or additional services rendered by other health care practitioners.

3. Universality (section 10)

   Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

   Newcomers to Canada, such as landed immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health services.

4. Portability (section 11)

   Residents moving from one province or territory to another must continue to be covered for insured health services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. The waiting period for eligibility to a provincial or territorial health care insurance plan must not exceed three months. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage.

   Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit a person to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

Prior approval by the health care insurance plan in a person's home province or territory may also be required before coverage is extended for elective (non-emergency) services to a resident while temporarily absent from their province or territory.

5. Accessibility (section 12)

   The intent of the accessibility criterion is to ensure insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances). In addition, the health care insurance plans of the province or territory must provide:

   - reasonable compensation to physicians and dentists for all the insured health services they provide; and
   - payment to hospitals to cover the cost of insured health services.

   Reasonable access in terms of physical availability of medically necessary services has been interpreted under the Act using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting "where" the services are provided and "as" the services are available in that setting.

The Conditions

1. *Information (section 13(a))* — the provincial and territorial governments shall provide information to the Minister of Health as may be reasonably required, in relation to insured health services and extended health care services, for the purposes of the CHA.
2. *Recognition (section 13(b))* — the provincial and territorial governments shall recognize the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

The provisions of the CHA, that discourage extra-billing and user charges for insured health services in a province or territory, are outlined in sections 18 to 21. If it can be determined that either extra-billing or user charges exist in a province or territory, a mandatory deduction from the federal cash transfer to that province or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health based on information provided by the province or territory according to the Extra-billing and User Charges Information Regulations described below.

Extra-billing (section 18)

Under the CHA, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e., a surgical-dentist providing insured health services in a hospital setting) in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province or territory. For example, if a physician were to charge patients any amount for an office visit that is insured by the provincial or territorial health insurance plan, the amount charged would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care and is therefore, contrary to the accessibility criterion.

User Charges (section 19)

The CHA defines user charges as any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health care insurance plan and is not payable by the plan. For example, if patients were charged a facility fee for receiving an insured service at a hospital or clinic, the fee would be considered a user charge. User charges are not permitted under the Act because as is extra-billing, they constitute a barrier or impediment to access.

Other Elements of the Act

Regulations (section 22)

Section 22 of the CHA enables the federal government to make regulations for administering the Act in the following areas:

- ☐ defining the services included in the CHA definition of "extended health care services."
- ☐ prescribing which services to exclude from hospital services;
- ☐ prescribing the types of information that the federal Minister of Health may reasonably require from a province or territory to qualify for a full federal transfer; and
- ☐ prescribing how provinces and territories are required to recognize the CHST in their documents, advertising or promotional materials.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges before the beginning of a fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (A copy of these regulations is provided in Annex A).

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the CHA, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHST (Canada Health Transfer effective April 1, 2004). For example, if it has been determined that a province has allowed $500,000 in extra-billing by physicians, the federal transfer payments to that province would be reduced by that amount.

Discretionary Penalty Provisions

Non-compliance with one of the five criteria or two conditions of the CHA is subject to discretionary penalties. The amount of any deduction from federal transfer payments under the CHST is based on the gravity of the default.

The CHA sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been applied.

Excluded Services and Persons

Although the CHA requires that insured health services are provided to insured persons in a manner that is consistent with the criteria and conditions set in the Act, not all Canadian residents or health services fall under the scope of the Act. There are two categories of exclusion for insured services:

- ☐ services that fall outside the definition of insured health services; and
- ☐ certain services and groups of persons are excluded from the definitions for insured services and insured persons.

These exclusions are discussed below.

Non-insured Health Services

In addition to the medically necessary insured hospital and physician services covered by the CHA, provinces and territories also provide a range of programs and services outside the scope of the Act. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services that may be provided include pharmacare, ambulance services and optometric services.

The additional services provided by provinces and territories may be targeted to specific population groups (e.g., children, seniors or social assistance recipients), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary and thus, are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court and cosmetic services.

Excluded Persons

The CHA definition of "insured person" excludes members of the Canadian Forces, persons appointed to a position of rank within the Royal Canadian Mounted Police, persons serving a prison term in a federal penitentiary, and persons who have not completed a minimum period of residence in a province or territory (a period that must not exceed three months). In addition, the definition of "insured health services" excludes services to persons provided under any other Act of Parliament (e.g., foreign refugees) or under the workers' compensation legislation of a province or territory.

The exclusion of these persons from insured health service coverage predates the adoption of the CHA and is not intended to constitute differences in access to publicly insured health care.

Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the CHA . These statements have been made in the form of ministerial letters from former federal health Ministers to their provincial and territorial counterparts. Both letters are reproduced in Annex B of this report.

Epp Letter

In June 1985, approximately one year following the passage of the CHA in Parliament, then-federal Health minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the CHA.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements on the federal policy intent, which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in assessing and interpreting compliance with the Act. The Epp letter continues to be an important reference for interpreting the Act.

Marleau Letter – Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal-provincial-territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal-Provincial-Territorial Health Ministers Meeting of September 1994 in Halifax, all ministers of health present, except for Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995, to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the CHA as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the CHA, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial or territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

Dispute Avoidance and Resolution Process

In April 2002, the then-federal Health Minister A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a Canada Health Act Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal, provincial and territorial interests of avoiding disputes related to the interpretation of CHA principles, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal-provincial-territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities are unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third-party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the CHA. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

Please refer to Annex C for a copy of Minister McLellan's letter.

Chapter 2 – Administration and Compliance

Administration

In administering the *Canada Health Act* (CHA), the federal Minister of Health is assisted by Health Canada policy, communications and information officers located in Ottawa and in the six regional offices of the Department, and by lawyers with the Department of Justice.

Health Canada takes its responsibilities under the *Canada Health Act* seriously, working with the provinces and territories to ensure that the principles of the CHA are respected. Our preference is always to work with provinces and territories to resolve issues through consultation, collaboration and cooperation.

The Canada Health Act Division

The Canada Health Act Division (the Division) is part of the Intergovernmental Affairs Directorate of the Health Policy Branch at Health Canada and is responsible for administering the CHA. Officers of the Division located in Ottawa and in regional Health Canada offices fulfill the following ongoing functions:

- ☐ monitoring and analysing provincial and territorial health insurance plans for compliance with the criteria, conditions and extra-billing and user charge provisions of the CHA;
- ☐ working in partnership with provinces and territories to investigate and resolve CHA compliance issues and pursue activities that encourage compliance with the CHA;
- ☐ informing the Minister of possible non-compliance and recommending appropriate action to resolve the issue;
- ☐ developing and producing the Canada Health Act Annual Report on the administration and operation of the CHA;
- ☐ developing and maintaining formal and informal contacts and partnerships with health officials in provincial and territorial governments to share information;
- ☐ collecting, summarizing and analysing relevant information on provincial and territorial health care systems;
- ☐ disseminating information on the CHA and on publicly funded health care insurance programs in Canada;
- ☐ responding to information requests and correspondence relating to the CHA through the preparation of responses to inquiries about the CHA and health insurance issues received by telephone, mail and the Internet, from the public, members of Parliament, government departments, stakeholder organizations and the media;
- ☐ conducting issue analysis and policy research in order to provide policy advice and recommendations to the Minister concerning the interpretation of the CHA; and
- ☐ collaborating with provincial and territorial health department representatives on the Interprovincial Health Insurance Agreements Coordinating Committee (see below).

Interprovincial Health Insurance Agreements Coordinating Committee

The Canada Health Act Division chairs the Interprovincial Health Insurance Agreements Coordinating Committee (formerly named the Federal-Provincial/Territorial Coordinating Committee on Reciprocal Billing), and acts as a secretariat for the Committee. The Committee was formed in 1991 to address issues affecting the interprovincial billing of hospital and medical services as well as issues related to registration and eligibility for health insurance coverage. It oversees the application of interprovincial health insurance agreements in accordance with the *Canada Health Act*.

The within-Canada portability provisions of the CHA are implemented through a series of bilateral reciprocal billing agreements between provinces and territories for hospital and physician services. This generally means that a patient's health card will be accepted, in lieu of payment, when the patient receives hospital or physician services in another province or territory. The province or territory providing the service will then directly bill the patient's home province. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. The intent of these agreements is to ensure that Canadian residents do not face point-of-service charges for medically required hospital and physician services when they travel in Canada. However, these agreements are interprovincial/territorial and signing them is not a requirement of the CHA.

In 2003-2004, the Committee updated hospital in-patient rates for all hospitals that bill for interprovincial services in Canada and updated the set of current national out-patient service rates.

The Committee is currently reviewing its high cost procedure (e.g. organ transplants) rates to reflect current costs.

Compliance

As mentioned in Chapter 1, provinces and territories must comply with the CHA criteria and conditions in order to receive the full amount of the Canada Health and Social Transfer (CHST) cash contribution (effective April 1, 2004, the cash contribution became payable under the Canada Health Transfer). The following section outlines how Health Canada determines provincial/territorial compliance.

Health Canada's approach to resolving possible *Canada Health Act* compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health ministry officials. In most instances, issues are successfully resolved through consultation and discussion based on a thorough examination of the facts. Deductions have only been applied when all options to resolve the issue have been exhausted. To date, most disputes and issues related to the administration and interpretation of the CHA have been addressed and resolved without resorting to deductions.

Health Canada officials routinely liaise with provincial and territorial health ministry representatives and health insurance plan administrators to help resolve common problems experienced by Canadians related to eligibility for health insurance coverage and portability of health services within and outside Canada.

Canada Health Act Division and regional office staff monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the CHA. Sources for this information include: officials representing provincial and territorial governments; provincial and territorial government publications; media reports and correspondence received from the public and other non-government organizations and individuals. Staff in the Compliance and Interpretation Unit, Canada Health Act Division, assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and making recommendations to the Minister for appropriate follow-up action. Verification of the facts with provincial and territorial health officials may reveal issues that are not directly related to the CHA while others may pertain to the CHA but are a result of misunderstanding or miscommunication and are resolved quickly with provincial assistance. In instances where a CHA issue has been identified and remains after initial enquiries, Division officials then ask the jurisdiction in question to investigate the matter and report back. Division staff then discuss the issue and its possible resolution with provincial officials. Only if the issue is not resolved to the satisfaction of the Division after following the aforementioned steps, do the penalty provisions of the Act come into consideration.

Compliance Issues

During 2003-2004, the Canada Health Act Division or the federal Minister of Health discussed or otherwise communicated the CHA concerns related to the following issues with the respective provincial/territorial Health Ministries. This information is factual as of March 31, 2004. Unless otherwise indicated, bilateral communications on these issues are on-going.

With respect to private payment for insured health services, Health Canada is concerned that any trend toward privatization that results in a two-tiered system, where individuals can pay for quicker access to medically necessary hospital or physician services represents a threat to the fundamental principles of the CHA, and therefore to the overall health care system. Access to insured services must be based on need, not the ability to pay.

Some jurisdictions have recently questioned the definition of the term "medically necessary" in the Act. As noted by former federal Health Minister Jake Epp in his 1985 interpretation letter to all provincial and territorial health ministers, provinces and territories, along with their medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces and territories determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care. In practice, this means that provincial and territorial health insurance plans, in consultation with their respective medical professional colleges or groups, are primarily responsible for determining which services are medically necessary for health insurance purposes. Once a service has been determined by a province to be an insured service, it must be covered by the provincial health insurance plan, regardless of where it is delivered.

Patient charges for magnetic resonance imaging (MRI) and computed tomography (CT) scans

There are private MRI and CT clinics in British Columbia, Alberta, Quebec and Nova Scotia, and these provinces do not provide coverage for medically necessary MRI and CT scans performed at these private clinics. Under the *Canada Health Act*, MRI and CT services are considered to be insured health services when they are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, and are provided in a hospital or a facility providing hospital care. Health Canada originally communicated these CHA concerns to all provinces in 2000, and a multilateral examination of the issue was subsequently conducted, however the issue of charges to insured persons for MRI and CT services was not resolved. In July 2003, former federal health minister Anne McLellan wrote to the four provincial health ministers concerned to communicate her objection to the queue jumping that results in provinces that allow private clinics to sell quicker access to medically necessary diagnostic services. Consultations with provincial officials in all four provinces except Quebec followed. Although multilateral discussions were scheduled to begin in 2004, these discussions were postponed at the request of the provinces, pending the First Ministers' discussions on sustainability of the health care system.

In 2003, Health Canada learned that a Newfoundland resident paid MRI Canada to arrange an MRI service under the guise of a third-party payer arrangement at a Newfoundland Hospital in July 2002. Health Canada relayed the CHA concerns about this situation to the Newfoundland and Labrador Department of Health and Community Services. Newfoundland responded that there are no plans to reimburse the patient. A Canada Health Transfer (CHT) deduction in respect of this charge will be taken if the issue is not resolved.

Patient charges by specialty referral centres and for self-referrals to physician specialists

Since 2002, two specialist referral clinics in Vancouver have been offering expedited consultations with physician specialists for a fee for individuals who choose to bypass their family physicians to seek specialized treatment. Charges to insured persons for insured services contravene the CHA. This practice is also a concern from a CHA perspective because it encourages queue jumping for insured health services. During a meeting between British Columbia Ministry of Health Services and Health Canada officials in 2003, the province indicated that Medical Services Plan (MSP) policy allows specialists to bill self-referred patients for the difference between the fee paid by MSP and the fee charged to self- referred patients. Health Canada officials informed the province that this practice constitutes extra-billing under the CHA and further bilateral consultations are required on this issue.

Patient charges for insured health services in private surgical clinics

Health Canada has been engaged in bilateral discussions with British Columbia on patient charges for insured health services in private surgical clinics since June 2000. Currently, the British Columbia *Medicare Protection Act* prohibits charges to insured provincial residents for medically necessary services, but allows third parties, e.g,. Workers' Compensation Board, to pay for these services. Some physicians working in private clinics allow insured residents to purchase health services under the guise of third-party payor arrangements. Health Canada has continued to press British Columbia to improve its capacity to audit and investigate charges at these facilities so that insured persons are not charged for insured health services. Following bilateral discussions, British Columbia passed the *Medicare Protection Amendment Act* (Bill 92) in December 2003. This legislation would have strengthened British Columbia's ability to audit and investigate those responsible for charging beneficiaries for insured health services, but it was not proclaimed. Health Canada officials had not indicated that legislative amendments were required, and left it to provincial officials to determine how best to resolve the problem of inappropriate patient charges. However, had this legislation come into effect, it would have addressed Health Canada's concerns. CHST deductions in respect of these charges were applied against the March 2004 CHST cash contribution, and future CHT deductions will be levied unless this issue is resolved.

Patient charges for bone density scans

In April 2002, the press reported that a Saskatchewan physician was providing preferred access to bone density scans to patients in return for a donation of $95 to a research foundation incorporated by the physician in 1995. Charges to insured persons for insured services contravene the CHA. This practice is a concern from a CHA perspective because it encourages queue-jumping for insured health services, and Health Canada subsequently communicated these concerns to Saskatchewan Health. In 2003, Saskatchewan Health informed Health Canada that they had exchanged correspondence with the physician about Saskatchewan's concerns and dissatisfaction with the practice. Health Canada has asked Saskatchewan about next steps.

Patient Charges for medical/surgical supplies

In September 2002, the press reported that Manitoba physicians were charging for medical/surgical supplies or "tray fees" to patients. Health Canada communicated the CHA concerns to Manitoba, namely, that charges to insured persons for insured services contravene the CHA. This issue was raised at a bilateral meeting between Health Canada and Manitoba Health officials in 2003, and Health Canada requested further information on Manitoba's policy regarding tray fees. Later in 2003, Health

Canada obtained evidence of tray fees having been charged to a Manitoba resident at a non-hospital medical/surgical facility, and subsequently wrote to Manitoba to request an investigation. A response is still pending.

Patient charges by a private surgical clinic

Following media reports in March 2000, the Régie de l'assurance maladie du Québec (RAMQ) launched an investigation into claims that a Quebec private clinic was charging patients up to $400 for the use of operating rooms to perform medical procedures for which physicians billed the RAMQ. Health Canada originally communicated the *Canada Health Act* concerns about insured persons being charged for insured health services to the Quebec Department of Health and Social Services in 2000, requesting details about the RAMQ investigation. In October 2002, press reports continued to indicate that the clinic was still charging patients. Health Canada has continued to advise Quebec that the practice of charging patients for the use of a facility during the provision of an insured service is a contravention of the CHA, and has made repeated requests that Quebec inform Health Canada of the results of its investigation into this practice. Quebec health ministry officials have responded that they are not at liberty to reveal the status of the province's investigation of the charges.

Drugs administered in hospitals

Health Canada is also concerned about patient charges for drugs administered in out-patient clinics of hospitals, and their appropriateness under the CHA. Some provinces cover such drugs e.g., Remicade, under provincial pharmacare programs rather than under hospital insurance programs. Health Canada officials have collected and are reviewing information provided by provinces during consultations on this issue.

Canada Health and Social Transfer (CHST) Deductions in 2003-2004

British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during 2001-2002, in accordance with the requirements of the CHA Extra-Billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST cash contribution, based on the Health Canada estimate for the amount of these changes, for the 2001-2002 fiscal year period.

With the closure of its abortion clinic in Halifax in November 2003, wherein patients were charged the facility fees in relation to the service, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Including adjustments for prior years, a net deduction of $7,119 was applied against Nova Scotia's CHST cash contribution during fiscal year 2003-2004.

History of Deductions and Refunds under the Canada Health Act

The *Canada Health Act*, which came into force April 1, 1984, reaffirmed the national commitment to the original principles of the Canadian health care system, as embodied in the previous legislation, the *Medical Care Act* and the *Hospital Insurance and Diagnostic Services Act*. By putting into place mandatory dollar-for-dollar penalties for extra-billing and user charges, the federal government took steps to eliminate the proliferation of direct charges for hospital and physician services, judged to be restricting the access of many Canadians to health care services due to financial considerations.

During the period 1984 to 1987, subsection 20(5) of the CHA provided for deductions in respect of these charges to be refunded to the province if the charges were eliminated before April 1, 1987. By March 31, 1987, it was determined that all provinces, which had extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of $244.732 million in deductions were refunded to New Brunswick ($6.886M), Quebec ($14.032M), Ontario ($106.656M), Manitoba ($1.270M), Saskatchewan ($2.107M), Alberta ($29.032M) and British Columbia ($84.749M).

Following the CHA's initial three-year transition period, under which refunds to provinces and territories for deductions were possible, penalties under the CHA did not reoccur until fiscal year 1994-1995. As a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan. This higher amount constituted extra-billing under the CHA. Including deduction adjustments for prior years, dating back to fiscal year 1992-1993, deductions began in May 1994 until extra-billing by physicians was banned when changes to British Columbia's *Medicare Protection Act* came into effect in September 1995. In total, $2.025 million was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992-1993 and 1995-1996. These deductions and all subsequent deductions are non-refundable.

In January 1995, the federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary services. As part of her communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given more than nine months to eliminate these user charges, but that any province that did not, would face financial penalties under the CHA. Accordingly, beginning in November 1995, deductions were applied to the cash contributions to Alberta, Manitoba, Nova Scotia and Newfoundland and Labrador for non-compliance with the Federal Policy on Private Clinics.

During the period from November 1995 to June 1996, total deductions of $3.585 million were made to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical, ophthalmological and abortion services. On October 1, 1996, Alberta prohibited private surgical clinics from charging patients a facility fee for medically necessary services for which the physician fee was billed to the provincial health insurance plan.

Similarly, due to facility fees allowed at an abortion clinic, a total of $284,430 was deducted from Newfoundland and Labrador's cash contribution before these fees were eliminated, effective January 1, 1998.

For the period from November 1995 to December 1998, deductions from Manitoba's CHST cash contribution amounted to $2,055,000, ending with the confirmed elimination of user charges at surgical and ophthalmology clinics, effective January 1, 1999. However, during fiscal year 2001-2002, a monthly deduction (from October 2001 to March 2002 inclusive) in the amount of $50,033.50 was levied against Manitoba's CHST cash contribution on the basis of a financial statement provided by the province showing that actual amounts charged with respect to user charges for insured services in fiscal years 1997-1998 and 1998-1999 were greater than the deductions levied on the basis of estimates. This brought total deductions levied against Manitoba to $2,355,201.

With the closure of its abortion clinic in Halifax effective November 27, 2003, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Prior to the closure, a total deduction of $372,135 was made from Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee.

In January 2003, British Columbia provided a financial statement in accordance with the CHA Extra-Billing and User Charges Information Regulations, indicating aggregate amounts actually charged with respect to extra-billing and user charges during fiscal year 2000-2001, totalling $4,610. Accordingly, a deduction of $4,610 was made to the March 2003 CHST cash contribution.

In 2004, British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during fiscal year 2001-2002, in accordance with the requirements of the CHA Extra-Billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST payment, based on the amount Health Canada estimated to have been charged during fiscal year 2001-2002.

Since the enactment of the *Canada Health Act*, covering the period April 1984 to March 2004, deductions totalling $8,753,151 have been applied against provincial cash contributions in respect of the extra-billing and user charges provisions of the *Canada Health Act*. This amount excludes deductions totalling $244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces as per subsection 20(5) of the CHA.

Evolution of Federal Health Care Transfers

Grants to help establish programs

Federal support for provincial health care goes back to the late 1940s when the National Health Grants were created. These grants were considered to be essential building blocks of a national health care system. While the grants were mainly used to build up the Canadian hospital infrastructure, they also supported initiatives in areas such as professional training, public health research, tuberculosis control and cancer treatment. By the mid 1960s, the grants available to the provinces totalled more than $60 million annually.

In the mid-1950s in response to public pressures, the federal government agreed to provide financial assistance to provinces to help them establish health insurance programs. In January 1956, the federal government placed concrete proposals before the provinces to inaugurate a phased health insurance program, with priority given to hospital insurance and diagnostic services. Discussions on these proposals led to the adoption of the *Hospital Insurance and Diagnostic Services Act* in 1957. The implementation of the Hospital Insurance and Diagnostic Services (HIDS) program started in July 1958, by which time Newfoundland, Saskatchewan, Alberta, British Columbia and Manitoba were operating hospital insurance plans. By 1961, all provinces and territories were participating in the program.

The second phase of the federal intervention supporting provincial and territorial health insurance programs resulted from the recommendations of the Royal Commission on Health Services (Hall Commission). In its final report, tabled in 1964, the Hall Commission recommended establishing a new program that would ensure that all Canadians have access to necessary medical care (physician services, outside a hospital setting).

The *Medical Care Act* was introduced in Parliament in early December 1966 and received Royal Assent on December 21,1966. The implementation of the Medical Care program started on July 1, 1968. By 1972, all provinces and territories were participating in the program.

Originally, the federal government's method of contributing to provincial and territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and

Deductions to Cash Contributions under the CHA: 1994-1995 through 2003-2004

(in dollars $)

Provinces/ Territories	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	TOTAL
NF	0	-46,000	-96,000	-132,000	-53,000	42,570	0	0	0	0	-284,430
PE	0	0	0	0	0	0	0	0	0	0	0
NS	0	-32,000	-72,000	-57,000	-38,950	-61,110	-57,804	-35,100	-11,052	-7,119	-372,135
NB	0	0	0	0	0	0	0	0	0	0	0
QC	0	0	0	0	0	0	0	0	0	0	0
ON	0	0	0	0	0	0	0	0	0	0	0
MB	0	-269,000	-588,000	-586,000	-612,000	0	0	-300,201	0	0	-2,355,201
SK	0	0	0	0	0	0	0	0	0	0	0
AB	0	-2,319,000	-1,266,000	0	0	0	0	0	0	0	-3,585,000
BC	-1,982,000	-43,000	0	0	0	0	0	0	-4,610	-126,775	-2,156,385
NW	0	0	0	0	0	0	0	0	0	0	0
NU	0	0	0	0	0	0	0	0	0	0	0
YK	0	0	0	0	0	0	0	0	0	0	0
TOTAL	-1,982,000	-2,709,000	-2,022,000	-775,000	-703,950	-18,540	-57,804	-335,301	-15,662	-133,894	-8,753,151

Note: Deductions are shown in the year they were applied to the cash contribution.
Deductions made in one fiscal year may include adjustments to previous fiscal year periods.

territories for approximately 50 percent of the costs of hospital insurance. Under the *Medical Care Act* (1966), the federal contribution was set at 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory. Funding protocols based on conditional grants continued until the move to block funding was made in fiscal year 1977-1978.

Established Programs Financing (EPF)

On April 1, 1977, federal funding supporting insured health care services was replaced by a block fund transfer with only general requirements related to maintaining a minimum standard of health services through the passage of the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, 1977. Known also as the EPF Act, the new legislation provided federal contributions to the provinces and territories for insured hospital and medical care services (as well as for post-secondary education) that were no longer tied to provincial expenditures. Rather, federal contributions made in fiscal year 1975-1976 under the existing cost-sharing programs were designated as the base year for contributions, to be escalated by the rate of growth of nominal Gross National Product (GNP) and increases to the population.

Under the EPF Act, and subsequent funding arrangements, the total amount of the provincial and territorial health entitlement was now made up of relatively equal cash and tax transfers. The federal tax transfer involves the federal government ceding some of its "tax room" to the provincial and territorial governments, reducing its tax rate to allow provinces to raise their tax rates by an equivalent amount. With the EPF "health" tax transfer, the changes in federal and provincial tax rates offset one another, meaning there was no net impact on taxpayers. The total amount of the health care entitlement did not change.

The EPF Act also included a new transfer for the Extended Health Care Services Program. This group of health care services, defined as nursing home intermediate care, adult residential care, ambulatory health care and the health aspects of home care, were block funded on the basis of $20 per capita for fiscal year 1977-1978, and subject to the same escalator as insured health services. This portion of the EPF transfer was made on a virtually unconditional basis and, unlike the insured services transfer, was not subject to specified program delivery criteria.

The health care portion of the EPF cash transfer was made on a semi-monthly basis to each province and territory by Health Canada. While this federal-provincial-territorial health care insurance funding arrangement did include certain program delivery criteria, Health Canada did not have a viable mechanism to compel the provinces and territories to fully comply with the conditions set out in the existing hospital and medical care legislation. Under the prevailing legislative framework, the Government of Canada was required to withhold all of the monthly health care transfer to a province or territory for each month if the conditions were not met.

It was not until the enactment of the *Canada Health Act* in 1984 that special deduction provisions came into force allowing for dollar-for-dollar deductions for extra-billing and user charges, and discretionary deductions when provincial and territorial plans failed to fully comply with other provisions set out in the Act. These criteria and conditions remain in force to the present day.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced a restructuring of the EPF Act, now to be called the *Federal-Provincial Fiscal Arrangements Act*, with special provisions for a Canada Health and Social Transfer (CHST). The new omnibus or block transfer, to begin in fiscal year 1996-1997, merged the health and post-secondary education funding of the EPF Act with Canada Assistance Plan funding (the federal-provincial cost-sharing arrangement for social services). When the CHST came into effect on April 1, 1996, provinces and territories received

CHST cash and tax transfer in lieu of entitlements under the Canada Assistance Plan (CAP) and Established Programs Financing. The combined value of EPF and CAP cash was greater than the CHST cash amount provided to provinces and territories, reflecting the need for fiscal restraint at the time the CHST was introduced.

Minor amendments to the CHA reflected a new definition for "cash contribution", and deletion of definitions for "Act of 1977" and "contribution". Revised wording of section 5 made cash contributions relating to all aspects of the CHA, eliminating the requirement for section 6 (for extended health care services). As well, the wording of sections 5 and 13(b) were changed to reference the CHST instead of the Act of 1977.

The new block fund was provided to support the national criteria and conditions in the *Canada Health Act* (public administration, comprehensiveness, universality, portability and accessibility) and the provisions relating to extra-billing and user charges, as well as maintaining the CAP- related national standard that no period of minimum residency be required or allowed with respect to social assistance. Extended health care services continued as part of the *Canada Health Act*, subject only to the provision of information and recognition of the federal transfer, as set out in section 13 of the *Canada Health Act*. To this day, these requirements remain unchanged since 1984.

The new legislation also transferred the cash payment authority from Health Canada to the Department of Finance. However, the Minister of Health continued to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act*, including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance before the payment dates. The Department of Finance makes the actual deductions, on behalf of the Department of Health, from the twice-monthly CHST cash contributions.

Health Accords: Increasing and restructuring federal support for health

In 2000 and 2003, First Ministers met to discuss health care, focusing on reform, reporting and funding requirements. In 2000, the federal government announced $23.4 billion in new spending over five years on health care renewal and early childhood development. Between 2001-2002 and 2005-2006, the government announced an additional $21.1 billion dollars for increases to the CHST cash contributions, as well as an additional $1.8 billion for targeted programs (medical equipment and primary health care reform), and $500 million for Canada Health Infoway.

In 2003, the government committed $36.8 billion over five years to support priority areas of reform (primary care, home care and catastrophic drugs) through increased CHST transfers ($14 billion) and new, targeted transfers ($16 billion for the Health Reform Transfer; $1.5 billion for medical equipment), as well as support for federal direct spending on health. This included $3.9 billion in unrealized CHST increases committed under the original timeframe of the 2000 Accord (up to and including 2005-2006).

The federal government also agreed to restructure the CHST to enhance the transparency and accountability of federal support for health and other social programs.

The Canada Health Transfer (CHT)

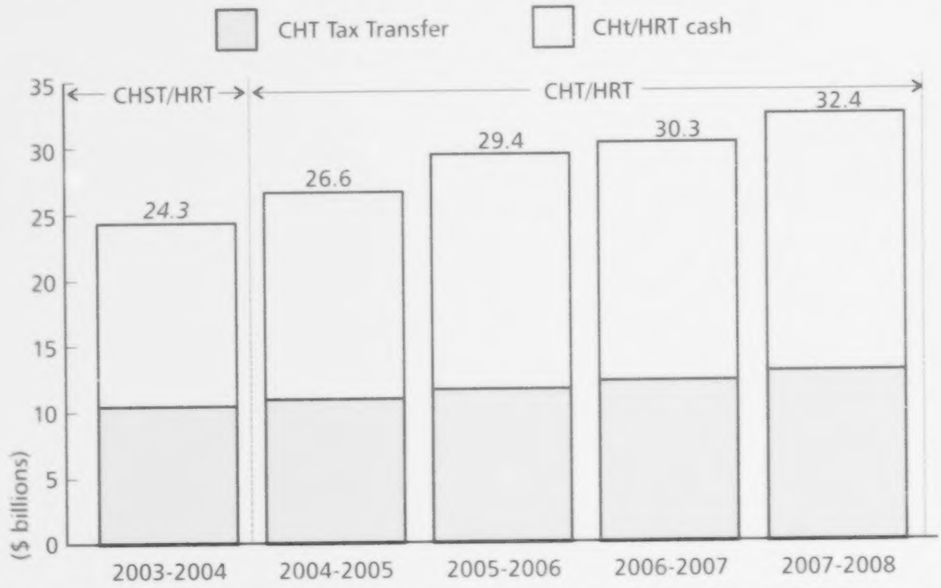
The CHST was restructured into two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST), effective April 1, 2004. The CHT supports the Government of Canada's ongoing commitment to maintain the national criteria and conditions of the *Canada Health Act*. The CST, a block fund that support post-secondary education and social assistance and social services, continues to give provinces and territories the flexibility to allocate funds among social programs according to their respective priorities.

The existing CHST-legislated amounts have been apportioned between the new transfers, with the percentage of cash and tax points allocated to each transfer reflecting provincial and territorial spending patterns among the areas supported by the transfers: 62 percent for the CHT and 38 percent for the CST.

The government's 2003 budget set out a long-term predictable, sustainable and growing funding framework for CHT and CST transfers, providing legislated cash levels up to 2007-2008, while the tax transfer component continues to grow in line with the economy. CHT cash and tax transfers are forecasted to be $25.1 billion in 2004-2005 ($14.3 billion in cash transfers, including CHST supplements, and $10.8 billion in tax transfers). CHT cash and tax transfers will reach $26.9 billion in 2007-2008. In total, over the five-year period of the Accord, cash support for health alone will grow by an average annual rate of 10.2 percent.

Targeted federal transfers supporting health

Health Reform: As part of the 2003 Accord on Health Care Renewal, the Government of Canada created a five-year, $16-billion Health Reform Transfer (HRT) to help provinces and territories accelerate reform in priority areas identified by First Ministers: primary care, home care and catastrophic drug coverage. First Ministers agreed to prepare annual public reports to their citizens on each of the reform areas using comparable indicators, to inform Canadians on progress achieved and key outcomes. Funding provided under the HRT will be integrated into the CHT, subject to a review by First Ministers by March



Canada Health Transfer and Health Reform Transfer

Legislated Framework

1 2003-2004 amount reflects notional share of Canada Health and Social Transfer (CHST) allocated to health, as CHT not in effect until 2004-2005, and the Health Reform Transfer (HRT).

2 Includes funding provided under the Canada Health Transfer (CHT); a portion of the 2003 CHST cash supplement notionally allocated to health, the 2004 CHST cash supplement for health and the HRT. Excludes targeted health funding provided under the Diagnostic and Medical Equipment Fund and Public Health and Immunization Fund.

31, 2008, of progress made in achieving reform objectives.

In 2004-2005, provinces and territories will receive $1.5 billion under the HRT, which is allocated on an equal per capita basis. All cash funding under the CHT, CST and HRT can be withheld under the *Canada Health Act*.

Medical Equipment: Under the 2000 and 2003 Accords, the federal government provided provinces and territories with $2.5 billion to enhance the availability of publicly funded diagnostic care and treatment services. The funds were paid to third-party trusts, giving provinces and territories the flexibility to draw down funds as required over the lifespan of the trusts. These funds were allocated on an equal per capita basis. As they did for the HRT, provincial and territorial governments were to report to Canadians on how they invested the funding.

Additional information on federal-provincial-territorial funding arrangements is available on request from the Department of Finance, or by visiting its Web site at:

http://www.fin.gc.ca/FEDPROV/FTPTe.html

History of Federal Transfers Related to Health Care

1957 *The Hospital Insurance and Diagnostic Services Act* is passed unanimously in both the House of Commons and the Senate, establishing a cost-shared program providing universal insurance coverage and access to hospital services to all residents of participating provinces. By 1961, all provinces and territories have joined this program.

1966 The Canada Assistance Plan (CAP) is introduced, enabling the federal government to pay for, among other things, half the cost of certain services required by persons deemed to be in need, but not funded though other federal programs, including the *Hospital Insurance and Diagnostic Insurance Act*.

1968 The *Medical Care Act* is enacted, establishing a cost-sharing program that empowers the federal Health Minister to make financial contributions to those provinces and territories that operate medical care insurance plans and meet minimum delivery criteria. By 1972, all provinces and territories are participating in this program.

1977 The *Federal-Provincial-Territorial Fiscal Arrangements and Established Programs Financing Act* (EPF Act) is passed. The Extended Health Care Services Program is established providing virtually unconditional per capita funding for certain types of long-term residential care services, home care and adult day care services.

1984 The *Canada Health Act* (CHA) is passed, amalgamating the provisions of the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*. The Act also includes the extended health care services provisions, which had previously been included under the EPF. The *Canada Health Act* now provides for dollar-for-dollar deductions regarding extra-billing and user charges, and discretionary deductions relating to other elements of the criteria and conditions set out in the Act.

The EPF Act is re-named *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*, 1977.

1995 It is announced in the federal budget that in "established programs" funding under the EPF Act and CAP cost sharing will be replaced by Canada Health and Social Transfer (CHST) block fund beginning April 1, 1996. CHST entitlements are set at $26.9 billion for 1996-1997. CHST entitlements for 1996-1997 are to be allocated in the same proportion as combined EPF and CAP entitlements for 1995-1996.

Section 6 of the CHA (amount payable for extended health care services) was deleted in 1995 to reflect the new fiscal arrangements adopted by the government (i.e., Canada Health and Social Transfer) that required one payment to provinces and territories rather than multiple payments. This change did not reduce the scope of insured health services under the Act. Extended health care services are not and never were insured health services under the CHA.

1996 A five-year CHST funding arrangement (1998-1999 to 2002-2003) is announced in the federal government budget. It provides a cash floor transfer to provinces and territories of $11 billion per year.

1998 The *Federal-Provincial-Territorial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act* is amended to put in place a $12.5 billion CHST cash floor, beginning in 1997-1998 and extending to 2002-2003.

1999 Increases in provincial and territorial CHST cash entitlements of $11.5 billion over five years are announced in the federal government budget. The $11.5 billion is provided to address fiscal pressures in the health care sector.

2000 Increased CHST funding of $2.5 billion to help provinces and territories fund health care and post-secondary education is announced in the February Budget. This brings CHST cash to $15.5 billion for each of the years from 2000-2001 to 2003-2004.

Following the First Ministers Meeting of September 11, 2000, the Prime Minister announces an increase in health funding through the CHST of more than $21 billion dollars in cash entitlements over five years. The new money addresses concerns raised by provincial and territorial governments that additional funds are needed to deal with immediate fiscal pressures in the health, post-secondary education and social services/social assistance sectors.

A $1billion Medical Equipment Fund is established to enable provinces and territories to immediately purchase and install medical equipment for diagnostic services and treatment. The Fund was allocated on an equal per capita basis in fiscal years 2000-2001 and 2001-2002.

2003 Federal transfers supporting provincial and territorial health care are restructured following the February 2003 Health Care Renewal Accord and the subsequent 2003 Budget. The CHST is augmented by the five-year $16 billion Health Reform Fund beginning in 2003- 2004. Two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST), are to be established by April 1, 2004, from a split in the CHST.

As part of the 2003 Accord, the federal government also provided provinces and territories with a three-year, $1.5 billion Diagnostic/Medical Equipment Fund to support specialized staff training and equipment that improves access to publicly funded diagnostic services.

Chapter 3 – Provincial and Territorial Health Care Insurance Plans in 2003-2004

The following chapter presents the 13 provincial and territorial health insurance plans that make up the Canadian publicly funded health insurance system. The purpose of this chapter is to demonstrate clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* (CHA) program criteria and conditions in 2003-2004.

Officials in the provincial, territorial and federal governments have worked together to provide and review the information. The information submitted to Health Canada for this report by each provincial and territorial department of health consists of two components:

☐ a narrative description of the provincial or territorial health care system relating to the five criteria and the first condition (that of providing the Minister of Health with information in relation to insured health services and extended health care services) of the CHA, which can be found following this chapter; and

☐ statistics identifying trends in the provincial and territorial health care systems, which are included at the end of each narrative description.

The first component is used to help with the monitoring and compliance of provincial and territorial health care plans with respect to the requirements of the CHA, while statistics identify current and future trends in the Canadian health care system.

To help prepare their submissions to the report, Health Canada has provided provinces and territories with the document *Canada Health Act Annual Report – 2003-2004: A Guide for Updating Submissions*. This guide is designed to help provinces and territories meet the reporting requirements of Health Canada and was developed through discussion with provincial and territorial officials. Annual revisions to the guide are based on Health Canad's analysis of health plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services.

The process for reporting to Health Canada for the current annual report was launched in a federal- provincial-territorial conference call held in April 2004, where a timetable was established for providing information to Health Canada and for producing the report.

Insurance Plan Descriptions

For the following chapter, provincial and territorial officials were asked to provide a narrative description of their health insurance plan according to the program criteria areas of the CHA in order to illustrate how the plans satisfy these criteria. This narrative description also includes information on how each jurisdiction met the CHA requirement for recognition of federal contributions that support insured and extended health care services and a section outlining the range of extended health care services in their jurisdiction; where extended health care includes nursing home intermediate care services, adult residential care services, home care services and ambulatory health care services.

Improvements to Accessing Health Care Services

During 2003-2004, provinces and territories continued to implement initiatives to ensure and enhance access by residents to insured health services. Examples of this include:

☐ the October 2003 opening of the Sir Thomas Ruddick hospital in Stephenville, Newfoundland, which provides hospital services to many rural communities;

☐ the opening of the Prince Edward Island Cancer Treatment Centre in November 2003, which allows most cancer patients to remain on the Island for their treatment;

☐ the announcement of funding to open 25 surgical beds and an additional operating room in the QEII Health Sciences Centre in Halifax, Nova Scotia, to improve access to hospital services and address emergency overcrowding;

☐ an announcement by New Brunswick in February 2004, of a two-year, five-site collaborative practice project to improve access to primary health services;

☐ during 2003-2004, Quebec increased the number of Family Medicine Groups to provide access to physician services 24 hours a day;

☐ the investment by Ontario of $385 million in funding to put hospitals on a sustainable footing, reduce wait times for surgeries and increase full-time nursing positions;

☐ the launch by Manitoba of the Health Services Wait Time Information Web site to help patients and physicians know how and where to find the timeliest care. In February 2004, Health Links-Info Santé was implemented to provide Manitobans with health care information 24 hours a day;

☐ the launch of the Target Time Frames for Surgery system by Saskatchewan, which will help patients receive surgical care according to their need. Funding of $15.3 million was announced to purchase medical equipment identified on a priority basis by the Regional Health Authorities;

☐ the launch of HealthLink Alberta and InformAlberta, two new Web sites to help Albertans access reliable health information and locate health services in their own health regions. In October 2003, Alberta implemented an Electronic Health Record that links physicians, pharmacists, hospitals, home care and other providers across the province, while maintaining the privacy and security of the information;

☐ an increase in funding of $6.7 million, announced in September 2003 to strengthen recruitment, retention and education of nurses across British Columbia; in May 2003, it was announced that 30 new spaces for nurse practitioners would be added to the University of British Columbia and the University of Victoria;

☐ in January 2004, an announcement was made of a pilot project at the Whitehorse General Hospital in Yukon to determine if the addition of knee replacement surgery would improve access to hospital services. In November 2003, it was announced that the Yukon Telehealth Project would expand to three additional sites;

☐ the completion in 2003 of Phase I and II of the new Inuvik Regional Hospital in the Northwest Territories. The last phase of the hospital will be completed in 2006; and

☐ the launch of the Ikajuruti Inungnik Ungasiktumi (IIU) telehealth network in Nunavut. The IIU network improves accessibility to health care services by increasing the frequency a patient will be seen by a specialist or their community physician and increasing the services from outside specialists at the community level.

Provincial and Territorial Health Care Insurance Plan Statistics

For 2003-2004, the statistical section of the annual report has been simplified and streamlined in response to feedback received from provincial and territorial officials and based on a review of data quality and availability. The statistical information is now located at the end of each provincial or territorial narrative.

The purpose of the statistical tables is to place the administration and operation of the CHA in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are within the scope of the Act.

The statistical tables contain resource and cost data for insured hospital, physician and surgical-dental by province and territory for five consecutive years ending on March 31.

All information has been provided by provincial and territorial officials. In order to ensure consistency in reporting, Health Canada provided provincial and territorial governments with a user's guide (*Canada Health Act Annual Report 2003-2004: A Guide for Updating Submissions*) that outlines what information to provide and how to present it. The guide was prepared in consultation with representatives in each provincial and territorial government.

Although efforts are made to capture data on a consistent basis, differences exist in the reporting on health care programs and services between provincial and territorial governments. Therefore, comparisons between jurisdictions are not made.

Provincial and territorial governments are responsible for the quality and completeness of the data they provide.

Organization of the Information

Information in the tables is grouped according to the nine subcategories described below.

Registered Persons

Registered persons are the number of residents registered with the health care insurance plans of each province or territory.

Public Facilities

Statistics on facilities providing insured hospital services, excluding psychiatric hospitals and nursing homes (which are not covered under the CHA), are provided in fields two and three.

Private-for-Profit Facilities

Measures four through six capture statistics on private-for-profit health care facilities that provide insured hospital services. These measures have been broken down into two sub-categories based on the services provided under the definition of insured hospital services in the CHA.

Insured Physician Services within Own Province or Territory

Statistics in this sub-section relate to the provision of insured physician services to residents in each province or territory, as well as to visitors from other regions of Canada.

Insured Services Provided to Residents in Another Province or Territory – Hospitals

This sub-section presents out-of-province or out-of-territory insured hospital services that are paid for by a person's home jurisdiction when they travel to other parts of Canada.

Insured Services Provided to Residents in Another Province or Territory – Physicians

This sub-section reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents.

Insured Services Provided Outside Canada – Hospitals

Hospital services provided out-of-country represent a person's hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory.

Insured Services Provided Outside Canada – Physicians

Physician services provided out-of-country represent a person's medical costs incurred while travelling outside of Canada that are paid by their home province or territory.

Insured Surgical-Dental Services Within Own Province or Territory

The information in this subsection describes insured surgical-dental services provided in each province or territory.

Newfoundland and Labrador

Introduction

Fourteen regional boards deliver the majority of the publicly funded health services in Newfoundland and Labrador. Of these, eight are institutional health boards, four are health and community services boards and two are integrated boards, delivering both institutional and community services. Included in the eight institutional boards are a provincial board for cancer services and a regional board for nursing homes, both located in St. John's.

The provincial government appoints health boards, whose members serve as volunteers. These boards are responsible for delivering health services to their regions and, in some cases, to the province as a whole, interacting with the public to determine health needs. The boards receive their funding from the provincial government, to which they are accountable. The Department of Health and Community Services provides the boards with policy direction and monitors programs and services.

In Newfoundland and Labrador almost 19,000 health care providers and administrators provide health services to the 519,000 residents.

In 2003-2004 improving community-based services was a major focus for the Department. The Department engaged in intensive, province-wide consultations on mental health. Over 800 individuals took part in the three-month process and the findings have provided the basis for developing a mental health strategy. In addition, significant investments were made in delivering health and community services. Medical and diagnostic equipment including a new Magnetic Resonance Imaging (MRI) unit and dialysis services were announced. Also, the Department continued to move forward with the Early Childhood Development initiative and the Provincial Primary Health Care Renewal Framework.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department include the Hospital Insurance Plan and the Medical Care Plan (MCP). Both plans are non-profit and are audited by the Auditor General of the Province.

The *Hospital Insurance Agreement Act*, amended in 1994, is the legislation that enables the Hospital Insurance Plan. The Act gives the Minister of Health and Community Services the authority to make Regulations for providing insured services on uniform terms and conditions to residents of the province under the conditions specified in the *Canada Health Act* and Regulations.

The *Medical Care Insurance Act* (1999) was assented to on December 14, 1999, and came into force on April 1, 2000. This Act empowers the Minister to administer a plan of medical care insurance for residents of the province. It allows for developing Regulations to ensure that the provisions of the statute meet the requirements of the *Canada Health Act* as it relates to administering of the medical care insurance plan.

There have been no legislative amendments to the *Medical Care Insurance Act* (1999) or the *Hospital Insurance Agreement Act* in 2003-2004.

The MCP facilitates the delivery of comprehensive medical care to all residents of the province by implementing policies, procedures and systems that permit appropriate compensation to providers for rendering insured professional services.

The MCP operates in accordance with the provisions of the *Medical Care Insurance Act* (1999) and Regulations, and in compliance with the criteria of the *Canada Health Act*.

1.2 Reporting Relationship

The Department is mandated with administering the Hospital Insurance and Medical Care Plans. The Department reports on these plans through the regular legislative processes e.g., Public Accounts.

The Department will be tabling its 2003-2004 Annual Report in the House of Assembly in fall 2004 under the Provincial Accountability Framework. All health boards and some health agencies will also table their reports.

The Department's Annual Report highlights the accomplishments of 2003-2004 and provides an overview of initiatives and programs that will continue to be developed in 2004-2005. The Report is a public document and is circulated to stakeholders. It will be posted on the Department's Web site.

1.3 Audit of Accounts

Each year the Province's Auditor General independently examines provincial public accounts. MCP expenditures are now considered a part of the public accounts. The Auditor General has full and unrestricted access to MCP records.

Hospital boards are subject to Financial Statement Audits, Reviews and Compliance Audits. Financial Statement Audits are performed by independent auditing firms that are selected by the boards under the terms of the *Public Tendering Act*. Review engagements, compliance audits and physician audits are carried out by personnel from the Department under the authority of the Newfoundland *Medical Care Insurance Act* (1999). Physician records and professional medical corporation records are reviewed to ensure that the record supports the service billed and that the service is insured under the Medical Care Plan.

Beneficiary audits are performed by personnel from the Department under the *Medical Care Insurance Act* (1999). Individuals are randomly selected on a bi-weekly basis.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* (1990) and the Hospital Insurance Regulations 742/96 (1996) provide for insured hospital services in Newfoundland and Labrador.

Insured hospital services are provided for in- and out-patients in 33 facilities (15 hospitals and 18 community health centres) and 14 nursing stations. Insured in-patient services include:

- ☐ accommodation and meals at the standard ward level;
- ☐ nursing services;
- ☐ laboratory, radiological and other diagnostic procedures;
- ☐ drugs, biologicals and related preparations;
- ☐ medical and surgical supplies, operating room, case room and anaesthetic facilities;
- ☐ rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology);
- ☐ out-patient and emergency visits; and
- ☐ day surgery.

Coverage policy for insured hospital services is linked to the coverage policy for insured physician services, although there is no formalized process. Ministerial direction is required to add to or to de-insure a hospital service from the list of insured services. The Department of Health and Community Services manages the process.

2.2 Insured Physician Services

The enabling legislation for insured physician services is the *Medical Care Insurance Act* (1999).

Other governing legislation under the *Medical Care Insurance Act* include:

- ☐ the Medical Care Insurance Insured Services Regulations;
- ☐ the Medical Care Insurance Beneficiaries and Inquiries Regulations; and
- ☐ the Medical Care Insurance Physician and Fees Regulations.

Licensed medical practitioners are allowed to provide insured physician services under the insurance plan. A physician must be licensed by the Newfoundland Medical Board to practise in the province.

Physicians can choose not to participate in the health care insurance plan as outlined in subsection 12(1) of the *Medical Care Insurance Act* (1999), namely:

"(1) Where a physician providing insured services is not a participating physician[1], and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:

(a) before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician and that the physician may so charge the beneficiary; and

(b) provide the beneficiary to whom the physician has provided the insured service with the information required by the minister to enable payment to be made under this Act to the beneficiary in respect of the insured service.

(2) Where a physician who is not a participating physician provides insured services through a professional medical corporation, the professional medical corporation is not, in relation to those services, subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services and the professional medical corporation and the physician providing the insured services shall comply with subsection (1)."

For purposes of the Act, the following services are covered:

- ☐ all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice;
- ☐ group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- ☐ diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and Regulations made under the Act.

There are no limitations on the services covered, provided they qualify under one or more of the conditions listed above.

Ministerial direction is required to add to or to de-insure a physician service from the list of insured services. This process is initiated following consultation by the Department with various stakeholders, including the provincial medical association. The Department manages the process and public consultation is involved.

2.3 Insured Surgical-Dental Services

The provincial Surgical-Dental Program is a component of the MCP. Surgical-dental treatments properly and adequately provided to a beneficiary and carried out in a hospital by a dentist are covered by the MCP if the treatment is of a type specified in the Surgical-Dental Services Schedule.

---

[1] The *Medical Care Insurance Act* (1999) defines "participating physician" as a physician who has not made an election, under subsection 7(3), to collect payments in respect of insured services rendered by him or her to residents, otherwise than from the Minister.

All dentists licensed to practise in Newfoundland and Labrador and who have hospital privileges are allowed to provide surgical-dental services. The dentist's licence is issued by the Newfoundland Dental Licensing Board.

Dentists may opt out of the Plan. These dentists must advise the patient of their opted-out status, stating the fees expected, and providing the patient with a written record of services and fees charged. One dentist is currently in an opted-out category.

Because the Surgical-Dental Program is a component of the MCP, management of the Program is linked to the MCP regarding changes to the list of insured services. The Department manages the process.

Addition of a surgical-dental service to the list of insured services must be approved by the Department.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the Plan include:

☐ preferred accommodation at the patient's request;
☐ cosmetic surgery and other services deemed to be medically unnecessary;
☐ ambulance or other patient transportation before admission or upon discharge;
☐ private duty nursing arranged by the patient;
☐ non-medically required x-rays or other services for employment or insurance purposes;
☐ drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital;
☐ bedside telephones, radios or television sets for personal, non-teaching use;
☐ fibreglass splints;
☐ services covered by Workers' Compensation legislation or by other federal or provincial legislation; and
☐ services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the Newfoundland Medical Board.

The use of the hospital setting for any services deemed not insured by the Medicare Plan would also be uninsured under the Hospital Insurance Plan.

For purposes of the *Medical Care Insurance Act* (1999), the following is a list of non-insured physician services:

☐ any advice given by a physician to a beneficiary by telephone;
☐ the dispensing by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
☐ the preparation by a physician of records, reports or certificates for, or on behalf of, or any communication to, or relating to, a beneficiary;
☐ any services rendered by a physician to the spouse and children of the physician;
☐ any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
☐ the time taken or expenses incurred in travelling to consult a beneficiary;
☐ ambulance service and other forms of patient transportation;
☐ acupuncture and all procedures and services related to acupuncture, excluding an initial assessment specifically related to diagnosing the illness proposed to be treated by acupuncture;
☐ examinations not necessitated by illness or at the request of a third party except as specified by the appropriate authority;
☐ plastic or other surgery for purely cosmetic purposes, unless medically indicated;
☐ testimony in a court;
☐ visits to optometrists, general practitioners and ophthalmologists solely for determining whether new or replacement glasses or contact lenses are required;
☐ the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;

☐ fluoride dental treatment for children under four years of age;
☐ excision of xanthelasma;
☐ circumcision of newborns;
☐ hypnotherapy;
☐ medical examination for drivers;
☐ alcohol/drug treatment outside Canada;
☐ consultation required by hospital regulation;
☐ therapeutic abortions performed in the province at a facility not approved by the Newfoundland Medical Board;
☐ sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
☐ *in-vitro* fertilization and OSST (ovarian stimulation and sperm transfer);
☐ reversal of previous sterilization procedure;
☐ surgical, diagnostic or therapeutic procedures not provided in facilities other than those listed in the Schedule to the *Hospitals Act* or approved by the appropriate authority under paragraph 3(d); and
☐ other services not within the ambit of section 3 of the Act.

All diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the province. Hospital policy on access ensures that third parties are not given priority access.

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of practice. Patients retain the right to financially upgrade the standard medical goods or services. Standards for medical goods are developed by the hospitals providing those services in consultation with service providers.

Surgical-dental and other services not covered by the Surgical-Dental Program are the dentist's, oral surgeon's or general practitioner's fees for routine dental extractions in hospital.

3.0 Universality

3.1 Eligibility

Residents of Newfoundland and Labrador are eligible for coverage under the provincial health care program.

The *Medical Care Insurance Act* (1999) defines a "resident" as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the province, but does not include tourists, transients or visitors to the province.

The Medical Care Insurance Beneficiaries and Inquiries Regulations (Regulation 20/96) identify those residents eligible to receive coverage under the plans. As the administrator of the Regulations, the MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications.

Persons not eligible for coverage under the plans include:

☐ students and their dependants already covered by another province or territory;
☐ dependants of residents if covered by another province or territory;
☐ certified refugees and refugee claimants and their dependants;
☐ foreign workers with Employment Authorizations and their dependants who do not meet the established criteria;
☐ foreign students and their dependants;
☐ tourists, transients, visitors and their dependants;
☐ Canadian Forces and Royal Canadian Mounted Police (RCMP) personnel;
☐ inmates of federal prisons; and
☐ armed forces personnel from other countries who are stationed in the province.

3.2 Registration Requirements.

Registration under the Medical Care Plan (MCP) and possession of a valid MCP card are required in order to access insured services. New residents are advised to apply for coverage as soon as possible on arriving in Newfoundland and Labrador.

It is the parent's responsibility to register a newborn or adopted child. The parents of a newborn child will be given a registration application upon discharge from hospital. Applications for newborn coverage will require, in most instances, a parent's valid MCP number. A birth or baptismal certificate will be required where the child's surname differs from the parents' surname.

Applications for coverage of an adopted child will require a copy of the official adoption documents, the birth certificate of the child, or a Notice of Adoption Placement from the Department. Applications for coverage of a child adopted outside Canada will require Permanent Resident documents for the child.

3.3 Other Categories of Individual

Foreign workers, clergy and dependants of North Atlantic Treaty Organization (NATO) personnel are eligible for benefits. Holders of Minister's Permits are also eligible, subject to MCP approval.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage on the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage on the day of arrival. The same applies to discharged members of the Canadian Forces, the RCMP and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the MCP. Immediate coverage is provided to persons from outside Canada who are authorized to work in the province for one year or more.

4.2 Coverage During Temporary Absences in Canada

Newfoundland and Labrador is a party to the Agreement on Eligibility and Portability regarding matters pertaining to portability of insured services in Canada.

Sections 12 and 13 of the Hospital Insurance Regulations (1996) define portability of hospital coverage during temporary absences both within and outside Canada. Portability of medical coverage during temporary absences both within and outside Canada is defined in Department of Health and Community Services policy.

Eligibility policy for insured hospital services is linked to the eligibility policy for insured physician services, although there is no formalized process.

Coverage is provided to residents during temporary absences within Canada. The Province has entered into formal agreements (i.e., the Hospital Reciprocal Agreement) with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In- patient, high-cost procedures and out-patient services are payable based on national rates agreed to by provincial and territorial health plans.

Except for Quebec, medical services incurred in all provinces or territories are paid through the Medical Reciprocal Agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the MCP for payment at host province rates.

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the province at least four consecutive months in each 12 month period to qualify as a beneficiary. Generally, the rules regarding medical and hospital care coverage during absences include:

☐ before leaving the province for extended periods, a resident must contact the MCP to obtain an out-of-province coverage certificate;

- ☐ beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate of up to 12 months' duration. Upon return, beneficiaries are required to reside in the province for a minimum four consecutive months. Thereafter, certificates will only be issued for up to eight months' coverage;
- ☐ students leaving the province may receive a certificate, renewable each year, provided they submit proof of full-time enrolment in a recognized school located outside the province;
- ☐ persons leaving the province for employment purposes may receive a certificate of up to 12 months' coverage. Verification of employment may be required;
- ☐ persons must not establish residence in another province, territory or country while maintaining coverage under the Newfoundland Medical Care Plan;
- ☐ for out-of-province trips of 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request;
- ☐ for out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside the province; and
- ☐ failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay the entire cost of any medical or hospital bills incurred outside the province.

Insured residents moving permanently to other parts of Canada are covered up to and including the last day of the second month following the month of departure. Coverage is immediately discontinued when residents move permanently to other countries.

4.3 Coverage During Temporary Absences Outside Canada

The Province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in- and out-patient services are covered for emergency, sudden illness and elective procedures at established rates. Hospital services will be considered under the Plan when the insured services are provided by a recognized facility (licensed or approved by the appropriate authority within the state or country in which the facility is located) outside Canada. The maximum amount payable by the Government's hospitalization plan for out-of-country in- patient hospital care is $350 per day, if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and hæmodialysis is $220 per treatment. The approved rates are paid in Canadian funds.

Physician services are covered for emergencies or sudden illness and are also insured for elective services not available in the province or within Canada. Physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in the province where they are available.

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals or licensed physicians in the other provinces and territories.

If a resident of the province has to seek specialized hospital care outside the country because the insured service is not available in Canada, the provincial health insurance plan will pay the costs of services necessary for the patient's care. However, it is necessary in these circumstances for such referrals to receive prior approval from the Department. The referring physicians must contact the Department or the MCP for prior approval.

Prior approval is not required for physician services; however, it is suggested that physicians obtain prior approval from the Plan so that patients may be made aware of any financial implications. General practitioners and specialists may request prior approval on behalf of their patients. Prior approval is not granted for out-of-country treatment of elective services if the service is available in the province or elsewhere within Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. There are no co-insurance charges for insured hospital services and no extra-billing by physicians in the province.

5.2 Access to Insured Hospital Services

In Newfoundland and Labrador there is a health care workforce of nearly 19,000 individuals. Half of this workforce belongs to regulated professional groups.

The supply of health professionals is a high-priority issue in this province, especially in rural areas.

The Provincial Health and Community Services Human Resource Planning Steering Committee completed its final report on human resource planning in fall 2003. The report summarized the committee's findings and provided key recommendations. Workforce forecasts were produced for 13 health occupations. In addition, the Department reported on employer-based indicator trends, completed a workforce supply analysis for registered nurses and licensed practical nurses, completed overall workforce retirement projections, and participated on an Early Retirement Committee, jointly chaired between Treasury Board Secretariat and the Newfoundland and Labrador Nurses' Union. The Department is also involved in an Atlantic Health Education/Training Planning study expected to conclude in March 2005. This project will allow the consolidation of human resource projections at the Atlantic level, permitting the four provinces to engage in joint training and education activities where opportunities exist.

The forecasts of the Health Human Resources Planning report showed potential shortages for some health occupations, mostly the younger, mobile, allied health groups where turnover is the highest. Generally the study found that while there are health human resource issues needing attention, stability in the system is expected in the next three to five years.

Continuing with the Department's commitment to encourage graduating health professionals to remain in this province, the Department offered a number of bursaries in exchange for return in service commitments. A total of approximately $1 million was spent in 2003-2004 on the awarding of thirty-seven physician and resident bursaries. In the allied health professions, 17 bursaries were awarded to students graduating from disciplines such as physiotherapy, occupational therapy, speech language pathology, audiology, clinical psychology and pharmacy. There were also 10 nurse practitioner bursaries awarded. Approximately 50 nursing students availed themselves of the Rural Student Nursing Incentive Program. As well, three scholarships were awarded by the Department through the Scholarships for Graduate Program in Health Administration program.

A new hospital was opened in Stephenville and operations were transferred from the old site. The new hospital, which cost $34.5 million to construct, contains 46 beds, a four-station haemodialysis unit, and offers services in general surgery, internal medicine, obstetrics/gynaecology, ophthalmology and mental health.

A new wing of the regional hospital in Gander was opened, which includes state-of-the-art operating rooms, intensive/coronary care units, emergency and out-patient departments and ancillary equipment and technology.

Best practices and operational reviews were carried out at some health boards to improve service delivery and curtail deficits.

Government invested $25.4 million in medical and diagnostic equipment in 2003-2004; $24.9 million from the federal government as part of the 2003 First Ministers' Accord on Health Care Renewal and $0.5 million from provincial sources. The funding was allocated to purchase equipment such as X-ray units, ultrasound units, nuclear medicine equipment and a second MRI machine. Preparations are now underway to establish the new MRI machine in Corner Brook.

A Provincial Kidney Program was established to set strategic directions for renal care in Newfoundland and Labrador. Two new satellite dialysis units were announced, bringing the number of dialysis sites to seven in the next one to two years.

Regarding the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services:

- ☐ an MRI unit is located in St. John's;
- ☐ Computed Tomography (CT) scanners are available in St. John's, Carbonear, Clarenville, Gander, Grand Falls/Windsor, Corner Brook, St. Anthony and Happy Valley/Goose Bay;
- ☐ renal dialysis is provided in St. John's, Clarenville, Grand Falls/Windsor, Corner Brook and Stephenville;
- ☐ cancer treatment is provided at the Dr. H. Bliss Murphy Cancer Centre, St. John's, and satellite clinics in Gander, Grand Falls/Windsor, Corner Brook and St. Anthony; and
- ☐ specialized surgical services are available at six regional hospitals.

Basic surgery is also offered at these locations and in seven district hospitals. Tertiary surgery, e.g. trauma, cardiac, neonatal and neurosurgery, are offered in St. John's. Quantenary care is not available. Provincial residents access this level of care at out-of-province facilities.

In October 2003, the Department established a provincial Task Force on Infection Control related to Communicable Diseases in Health Institutions and Ambulance Services. The Task Force's mandate was to assess the current state of infection control practices, procedures and resources in the institutional health sector and provide recommendations on improvements as indicated. The Task Force presented its findings in winter 2003. They are being reviewed by Government.

Following an extensive public consultation, the Department approved a provincial primary health care renewal framework, *Moving Forward Together: Mobilizing Primary Health Care*. The Framework outlines the structure for remodelling primary health care in Newfoundland and Labrador through an incremental approach.

The Framework supports four goals: (1) enhanced access to, and sustainability of, primary health care; (2) an emphasis on self reliant and healthy citizens and communities; (3) promotion of a team-based, interdisciplinary and evidenced-based approach to services provision; and (4) enhanced accountability and satisfaction of health professionals. Provincial supports included establishing of the Office of Primary Care, the Primary Health Care Advisory Council, linkages with local college and university programs and professional associations, and developing provincial working groups to support learning/problem-solving and provider capacity-building.

Seven proposals for interdisciplinary, team-based, primary health care projects across the province were approved.

Primary health care working groups were initiated to develop partnerships, processes and tools for scope of practice shifts, physician payment models and information management. The initial focus was on the electronic health record.

Agreements on two Atlantic projects were reached: Building a Better Tomorrow Initiative (BBTI) and Self-care Telecare. The BBTI will support team and inter-professional development and change management in project areas. A needs assessment for 24/7 telephone advice service was also initiated through the Self-care Telecare project.

A discussion document, *Working Together for Mental Health: A Proposed Mental Health*

Services Strategy for Newfoundland and Labrador, was released and was followed by a three month consultation process including over 800 individuals.

The report *Investing in Health - A Report on Public Health Capacity in Newfoundland and Labrador* summarized the findings on public health capacity and made recommendations for future actions to ensure health protection, injury prevention and protection of the population from existing and emerging communicable and chronic diseases.

The integrated Public Health Information System (iPHIS) developed by Health Canada was piloted in the Eastern Region of the province as a tool to optimize disease surveillance and case management.

5.3 Access to Insured Physician and Surgical-Dental Services

The number of physicians practising in the province has been relatively stable, with an upward trend since 2003. The Department is committed to working with regional health boards to develop a provincial human resource plan for physicians based on the principle of access to services.

During 2003-2004, four new physicians began practice in the province who had previously received financial assistance from one of the Department's bursary programs. A total of 37 new awards were issued to students and residents in different years of training in 2003-2004, a significant increase over previous years.

5.4 Physician Compensation

The legislation governing payments to physicians and dentists for insured services is the *Medical Care Insurance Act* (1999).

The current methods of remuneration to compensate physicians for providing insured health services include fee-for-service, salary, contract and sessional block funding.

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association (NLMA), with involvement of the Newfoundland and Labrador Health Boards Association, using traditional and formalized negotiation methods. Arising from the most recent agreement, the Physician Services Liaison Committee was formed in October 2002, to provide a mechanism whereby medical issues of mutual concern can be addressed cooperatively between the Government and the NLMA.

In 2003, an arbitrated award was reached with the provincial medical association which resulted in a three year agreement being implemented in May 2003. The total value of the award was $54 million dollars over three years. The award was unique in that it included varying increases to different fee-for-service physician groups based upon fee rate comparisons with their Maritime peers, dedicated dollars to increase Emergency Department rates, a universal on-call payment policy and salary increases of 18 percent.

The dispute resolution in the agreement to determine deficits or surplus for fee-for-service funding is Arbitration under the *Arbitration Act*.

5.5 Payments to Hospitals

The Department is responsible for funding regional boards for ongoing operations and capital purchases. Funding for insured services is provided to the boards as an annual global budget and is distributed in 12 monthly advance payments. Payments are made to regional boards in accordance with the *Hospital Insurance Agreement Act* (1990) and the *Hospitals Act*. As part of their accountability to the Government, boards are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. The global budgeting process devolves the budget allocation authority, responsibility and accountability to all appointed boards in the discharge of their mandates.

Throughout the fiscal year, the health boards may forward additional funding requests to the

Department for changes in program areas or increased workload volume. These requests will be reviewed and, if approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for negotiated salary increases, additional approved positions or program changes, are funded based on the implementation date of such increases and the cash flow requirement in a given fiscal year.

Boards are continually facing challenges in addressing increased demands when costs are rising, staff workloads are increasing, patient expectations are higher and new technology introduces new demands for time, resources and funding. Boards are continuing to work with the Department to address these issues and provide effective, efficient and quality health services.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health and Social Transfer (CHST) has been recognized and reported by the Government of Newfoundland and Labrador through press releases, government Web sites, and various other documents. For fiscal year 2003-2004, these documents included:

☐ the 2003-2004 Public Accounts Volume I;
☐ the Estimates 2004-2005; and
☐ the Budget Speech 2004.

These reports, tabled by the Government to the House of Assembly, are publicly available to Newfoundland and Labrador residents and have been shared with Health Canada for information purposes.

7.0 Extended Health Care Services

Newfoundland and Labrador has established long-term residential and community-based programs as alternatives to hospital services. These programs are provided by seven regional boards. Services include the following:

☐ Long-term residential accommodations are provided for clients requiring high levels of nursing care in 18 community health centres and 22 nursing homes. There are approximately 2,800 beds located in these 40 facilities. Residents pay a maximum of $2,800 per month based on each client's assessed ability to pay, using provincial financial assessment criteria. The balance of funding required to operate these facilities is provided by the Department.
☐ Persons requiring protective oversight or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 2,400 beds located in 110 homes across the province. These homes are operated by the private for-profit sector. Residents pay a maximum of $1,110 per month, based on an individual client assessment using standardized financial criteria.

Home Care Services

Home care services include professional and non-professional supportive care to enable people to remain in their own homes for as long as possible without risk. Professional services include nursing and some rehabilitative programs. These services are publicly funded and delivered by staff employed with six regional boards. Non-professional services include personal care, household management, respite and behavioural management. These services are delivered by home support workers through agency or self-managed care arrangements. Eligibility for non-professional services is determined through a client financial assessment using provincial criteria. The current ceiling for home support services is $2,707 for seniors and $3,875 for persons with disabilities.

Special Assistance Program

The Special Assistance Program is a provincial program that provides basic supportive services to assist financially eligible clients in the community with activities of daily living. The benefits include access to health supplies, oxygen, orthotics and equipment.

Drug Programs

The Senior Citizens' Drug Subsidy Program is provided to residents over 65 years of age who receive the Guaranteed Income Supplement and who are registered for Old Age Security benefits. Eligible individuals are given coverage for the ingredient portion of benefit prescription items. Any additional cost, such as dispensing fees, are the client's responsibility. Income support recipients are eligible for the Social Services Drug Plan, which covers the full cost of benefit prescription items, including a set markup amount and dispensing fee.

Other Programs

The Department administers the Emergency Air and Road Ambulance Programs through the Emergency Health Services Division.

The Road Ambulance Program provides quality pre-hospital emergency and routine treatment, care and transportation. It also includes the transfer of patients between facilities and return of patients to their place of residence. Road ambulances are operated by 59 organizations – 30 private companies, 22 community or volunteer groups, and seven regional health boards throughout the province.

The Air Ambulance Program provides air transport to patients requiring emergency care who could not be transported by a commercial airline or by road ambulance because of urgency or time, or remoteness of location. This program uses two fixed-wing aircraft and five chartered helicopters. These helicopters are also used for routine transportation of doctors and nurses to remote communities for clinics. A third fixed wing aircraft is used in Labrador for regional medical services transports, including routine appointments by coastal residents in Happy Valley/Goose Bay.

Residents who travel by commercial air to access medically necessary insured services that are not available within their area of residence or within the province, may qualify for financial assistance under the Medical Transportation Assistance Program. This program is administered by the Department. Kidney donors and bone marrow/stem-cell donors are eligible for financial assistance, as administered by the Health Care Corporation of St. John's, when the recipient is a Newfoundland and Labrador resident eligible for coverage under the Newfoundland Hospital Insurance and Medical Care Plans.

The Dental Health Plan incorporates a children's dental component and a social assistance component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at six-month intervals; cleanings at 12-month intervals; fluoride applications at 12-month intervals for children aged 6 to 12; x-rays (some limitations); fillings and extractions; and some other specific procedures that require approval before treatment. Services are available under the social assistance component to recipients of social assistance who are 13 to 17 years of age: examinations (every 24 months); x-rays (with some limitations); routine fillings and extractions; emergency extractions, when the patient is seen for pain, infection, or trauma. Adults receiving social assistance are eligible for emergency care and extractions. Beneficiaries covered under the Dental Health Plan must pay a co-payment amount directly to the dentist for each service provided (e.g., fillings, extractions, etc.), except for examinations, dental cleanings, fluoride applications, radiographs and retention pins for fillings. In circumstances where the beneficiary is receiving income support, the co-payment is paid by the Dental Health Plan.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#).	618,118 [1]	616,944 [2]	565,000 [3]	560,644 [4]	599,907 [5]

Insured Hospital Services Within Own Province or Territory

Public Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
2. Number (#):					
a. acute care	33	32	32	32	33
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	0	0	0	0	0
e. total	33	32	32	32	33
3. Payments ($):					
a. acute care	509,018,766	537,428,824	619,884,087	672,874,609 [6]	681,953,170 [6]
b. chronic care	0	0	0	0	
c. rehabilitative care	0	0	0	0	
d. other	0	0	0	0	
e. total	509,018,766	537,428,824	619,884,087	672,874,609 [6]	681,953,170 [6]
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	1	1	1	1	1
b. diagnostic imaging facilities	0	0	0	0	0
c. total	1	1	1	1	1
5. Number of insured hospital services provided (#):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	0	0	0	0	0
c. total	not available	not available	not available	not available	not available
6. Payments ($):					
a. surgical facilities	387,030	270,750	338,200	286,425	280,250
b. diagnostic imaging facilities	0	0	0	0	0
c. total	387,030	270,750	338,200	286,425	280,250

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#): [7]					
a. general practitioners	432 [8]	437 [8]	448 [8]	478 [8]	414 [8]
b. specialists	480 [8]	485 [8]	504 [8]	500 [8]	545 [8]
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	912 [8]	922 [8]	952 [8]	978 [8]	959 [8]
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	2,489,000	2,340,000	2,263,000	2,147,000	2,109,987
b. specialists	2,443,000	2,318,000	2,218,000	2,206,000	1,843,902
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	4,932,000	4,657,000	4,481,000	4,353,000	3,953,889
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	42,429,000	43,251,000	42,751,000	50,961,000	62,613,000
b. specialists	72,780,000	73,239,000	75,177,000	78,157,000	90,739,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	115,209,000	116,490,000	117,928,000	129,118,000	153,352,000
12. Average payment per fee for service service ($):					
a. general practitioners	17.05	18.49	18.89	23.74	23.97
b. specialists	29.79	31.60	33.90	35.43	38.79
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	23.36	25.01	26.32	29.66	31.38
13. Number of services provided through all payment methods (#): [9]					
a. medical	3,104,000	2,878,000	2,728,000	2,607,000	not available
b. surgical	468,000	433,000	398,000	379,000	not available
c. diagnostic	1,361,000	1,346,000	1,345,000	1,367,000	not available
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	4,932,000	4,657,000	4,481,000	4,353,000	3,953,889
14. Total payments to physicians paid through all payment methods ($): [9]					
a. medical	72,500	71,987	not available	not available	not available
b. surgical	10,923	10,834	not available	not available	not available
c. diagnostic	31,786	33,670	not available	not available	not available
d. other	not applicable	not applicable	not applicable	not available	not available
e. total	115,209,000	116,490,000	117,928,000	129,118,000	153,352,000
15. Average payment per service, all payment methods ($): [9]					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not applicable	not applicable	not available	not available	not available
e. all services	23.36	25.01	26.30	29.66	31.38

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	1,549	1,699	1,681	1,588	1,640
17. Total number of claims, out-patient (#).	25,546	24,929	26,155	26,464	26,305
18. Total payments, in-patient ($).	10,144,354	10,608,368	10,312,515	10,817,595	12,397,072
19. Total payments, out-patient ($).	3,138,582	3,047,375	3,213,978	3,488,186	3,303,844
20. Average payment, in-patient ($).	6,549.00	6,244.00	6,135.00	6,812.00	7,559.00
21. Average payment, out-patient ($).	123.00	122.00	123.00	132.00	126.00
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	161,000	173,000	143,000	143,000	121,072
23. Total payments ($).	4,327,000	4,562,000	4,082,000	4,231,000	4,222,118
24. Average payment per service ($).	28.41	26.35	28.56	29.57	34.87

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	73	111	62	61	62
26. Total number of claims, out-patient (#).	260	287	258	278	283
27. Total payments, in-patient ($).	198,072	1,102,540	123,692	269,963	363,153
28. Total payments, out-patient ($).	15,626	36,260	22,567	18,432	167,588
29. Average payment, in-patient ($).	2,713.00	9,933.00	1,995.00	4,426.00	5,857.00
30. Average payment, out-patient ($).	60.00	126.00	87.00	66.00	592.00
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	4,000	6,000	4,000	3,000	5,342
32. Total payments ($).	107,000	424,000	67,000	172,000	473,460
33. Average payment per service ($).	19.61	70.16	16.37	54.30	88.63

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	35	35	26	33	not available
35. Number of services provided (#).	9,000	11,000	10,000	11,000	not available
36. Total payments ($).	354,000	389,000	409,000	419,000	not available
37. Average payment per service ($).	38.73	35.06	39.82	37.76	not available

Endnotes

1. Data are as of March 1, 2000.
2. Data are as of April 11, 2001.
3. Data as of April 30, 2002.
4. Data as of April 15, 2003.
5. Data as of May 17, 2004.
6. New Methodology for 2002-2003. Operating costs only: does not include capital, deficit or non-government funding. Payments represent the final provincial plan funding provided to regional health care boards for the purposes of delivering insured acute care services.
7. Excludes inactive physicians.
8. Total Salaried and Fee-for-service.
9. Fee-for-Service only.

Prince Edward Island

Introduction

The Ministry of Health and Social Services is a very large and complex system of integrated services that protect, maintain and improve the health and well-being of Prince Edward Islanders. The continued sustainability of the system is a primary concern. Spending on health and social services has grown rapidly in recent years to 42 percent of the total provincial government program expenditures. The availability of health professionals is also affecting our ability to sustain services.

We are concerned about the high rate of chronic conditions in our province: conditions such as cardiovascular disease, cancer, diabetes and mental illness. Wellness initiatives will help Islanders increase their acceptance of responsibility for their health and to reach their full health potential. This will be achieved through community partnerships to promote healthy lifestyles and to reduce risk factors for chronic disease, and through increased access to primary health services that support disease prevention and management.

Recruitment, retention and human resource planning will remain a priority to ensure an adequate supply and appropriate mix of health and social service professionals to meet changing needs. Retention initiatives are supported by comprehensive workplace wellness programs that promote organizational excellence, positive personal health practices and safe, positive workplaces.

Overview of the Health and Social Services System

Prince Edward Island has a publicly administered and funded health system that guarantees universal access to medically necessary hospital and physician services as required by the *Canada Health Act*. Many other health and social services are funded in whole, or in part, by the provincial government. The system includes a wide range of integrated health and social services such as acute care, addictions, mental health, social assistance and housing services. In addition, some specialty services such as cardiac surgery and neurotrauma services are offered in two referral hospitals within the purview of the Provincial Health Services Authority.

In December 2002, the Prince Edward Island health system underwent restructuring. The Provincial Health Services Agency was created to administer all acute care hospital services including cancer treatment, mental health and addictions within two referral hospitals. The Eastern Kings and Southern Kings Regional Health Authorities were merged to form the Kings Regional Health Authority.

Facilities

Prince Edward Island has two referral hospitals and five community hospitals, with a combined total of 474 beds. Along with seven government manors that house 558 (+ 10 respite) long-term care nursing beds, Islanders have access to an additional 389 (+11 temporary beds) in private nursing homes. The system also operates several addictions and mental health facilities, 1,167 seniors' housing units and 461 family housing units.

Construction of a new $50 million health facility was completed and opened in April 2004 in Summerside. Computed Tomography (CT) scanning and a wide range of diagnostic imaging services are available at the referral hospitals. A new linear accelerator and Magnetic Resonance Imaging (MRI) services are now operating.

Human Resources

The public sector health and social services workforce has approximately 4,000 employees. Prince Edward Island has 200 health care professionals per 10,000 residents, compared with the national average of 182 per 10,000[1].

Structure

The system includes the Department of Health and Social Services, the Provincial Health Services Authority (PHSA) and four Regional Health Authorities, which are governed by the Regional Health Boards. The Department works with the Regional Health Authorities and the PHSA to establish system goals and objectives, develop policy and outcome standards and allocate resources. The Regional Health Authorities plan and deliver primary health care and social services. The PHSA is responsible for delivering of acute care services across Prince Edward Island.

Financial Resources

During the past 10 years, provincial spending on health and social services increased from $270 million to more than $410 million in 2003-2004, an average increase of about five percent per year. Increased costs are due to inflation, population growth, new technologies and the increasing use of services by all age groups.

Major health and social services expenditures are allocated to: Hospital Services, 31 percent; Social Services, 21 percent; Long Term Care, 10 percent; Physician Services, 12 percent; and other services such as Provincial Drug Programs, Public Health Nursing and Addiction Services, 26 percent.

Critical Issues

Supply of health professionals

Maintaining an adequate supply of workers is one of the most critical issues facing the system. Recruitment and retention of skilled employees are expected to be a challenge throughout the labour market in coming years due to a major demographic shift. The effect of this trend is being felt first in the health sector, which is labour-intensive and depends on a specialized workforce, and particularly in less-populated areas such as Prince Edward Island. The supply of health professionals is now decreasing as the workforce ages, the number of people retiring increases and the supply of available health care graduates declines. To address this issue, the system must increase its focus on workplace wellness and human resource planning to ensure an adequate supply and the right mix of health professionals to meet changing needs.

Public expectation and demand

The demand for services is increasing in almost every area for a variety of reasons, including population growth, the availability of new drugs and technology and increasing public expectations. Residents are asking for more doctors, nurses, drugs, technology and family services. They want access to care in their own communities. They are also concerned about waitlists for services. While rising expectations are creating pressure to increase spending on acute care, they are severely limiting the ability of the system to innovate and shift resources to other areas of need.

Increasing public expectation is a very critical issue. Demand alone cannot drive the system. The public must become more informed about reasonable access and the need for real changes in the way services are delivered, particularly in primary health services.

---

[1] Canadian Institute for Health Information, 1997.

Appropriate access to primary health services

There is growing evidence that investments in primary health services have a great impact on health and sustainability. Primary health services are those that people access first and most often, such as family physician services, public health nursing, screening programs, addiction services and community mental health services.

Personal health practices

People's capacity to accept responsibility for their health is influenced by social and economic conditions. Comprehensive strategies are needed to address these conditions. It is critical that the health system increase its capacity to work with others to help individuals, families and communities accept responsibility for, and achieve, good health.

Aging population

As baby boomers age, we will experience the biggest demographic shift in history. It is expected that the proportion of the population aged 65 and over in Prince Edward Island will increase from 13 percent today to 15 percent in 2011 and to 27 percent in 2036. This will affect the health system in several ways. The incidence of diseases such as cancer, heart disease, diabetes and dementia is expected to increase. Demand is expected to rise for acute care, long-term care, home care, mental health and other services. This issue becomes more critical when we consider that the health care workforce will be aging at the same time, there will be fewer family members to support their aging parents, and the amount of resources required to sustain services for seniors could negatively affect other government services that support health. It is critical that the health system be prepared to meet these changing needs.

Disease prevention and management

Many diseases are preventable. For example, meningitis can be prevented through vaccination. The spread of sexually transmitted diseases can be prevented through responsible sexual behaviour. Many chronic conditions are also preventable. Risk factors for cardiovascular disease and cancer can be reduced or eliminated through education and supports that result in a change in lifestyle.

The World Health Organization suggests that diabetes is rising in epidemic proportions worldwide. Prince Edward Island had 17 new cases of diabetes diagnosed each month in the mid- 1970s, compared with 45 cases per month in the mid-1990s. It is projected that this number will grow to 65 cases per month in 2006. There is clear and undisputable evidence that effective blood sugar control can prevent or delay the onset of serious complications from diabetes, such as heart disease, blindness and kidney disease, which have enormous human and financial costs. The prevalence of cancer and diabetes in this province is expected to increase significantly as the population ages. It is imperative that our system step up its efforts to help Islanders prevent, delay and manage these conditions.

The Department in partnership with other sectors, released a comprehensive and integrated Provincial Strategy for Healthy Living in June 2003 in order to improve the health of Islanders. Focusing on tobacco reduction, healthy eating and physical activity, promising strategies for promoting population health in Prince Edward Island include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. Goals of the Strategy are: to reduce the growth in the prevalence of preventable chronic disease in Prince Edward Island; to reduce tobacco use and the harm it causes to the population of Prince Edward Island; to increase the number of Islanders who participate in regular physical activity in sufficient quantity to promote optimal health; to improve healthy eating habits that support good nutritional health; and to increase capacity for health promotion and chronic disease prevention. The current focus of the Strategy includes developing regional networks, internal and external communication strategies, and an evaluation framework. Healthy Living Coordinators were hired in two of the four Regional Authorities in 2003-2004. The Coordinators will help move the strategy forward at the community level.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Hospital Care Insurance Plan, under the authority of the Minister of Health and Social Services, is the vehicle for delivering hospital care insurance in Prince Edward Island. The enabling legislation is the *Hospital and Diagnostic Services Insurance Act* (1988), which insures services as defined under section 2 of the *Canada Health Act*.

Under Part I of the *Hospital and Diagnostic Services Insurance Act*, it is the function of the Minister, and the Minister has the power, to:

☐ ensure the development and maintenance throughout the province of a balanced and integrated system of hospitals and schools of nursing and related health facilities;

☐ approve or disapprove the establishment of new hospitals and the establishment of, or additions to, related health facilities;

☐ approve or disapprove all grants to hospitals for construction and maintenance;

☐ establish and operate, alone or in cooperation with one or more organizations, institutes for training hospital and related personnel;

☐ conduct surveys and research programs and to obtain statistics for its purposes;

☐ approve or disapprove hospitals and other facilities for the purposes of the Act in accordance with the Regulations; and

☐ subject to the approval of the Lieutenant Governor in Council, to do all other Acts and things that the Minister considers necessary or advisable for carrying out effectively the intent and purposes of the Act.

In addition to the duties and powers enumerated in Part I of the Act, it is the function of the Minister, and the Minister has power, to:

☐ administer the plan of hospital care insurance established by this Act and the Regulations;

☐ determine the amounts to be paid to hospitals and to pay hospitals for insured services provided to insured persons under the plan of hospital care insurance and to make retroactive adjustments with hospitals for under-payment or over-payment for insured services according to the cost as determined in accordance with the Act and the Regulations;

☐ receive and disburse all monies pertaining to the plan of hospital care insurance;

☐ approve or disapprove charges made to all patients by hospitals in Prince Edward Island to which payments are made under the plan of hospital care insurance;

☐ enter into agreements with hospitals outside Prince Edward Island and with other governments and hospital care insurance authorities established by other governments for providing insured services to insured persons;

☐ prescribe forms necessary or desirable to carry out the intent and purposes of the Act;

☐ appoint inspectors and other officers with the duty and power to examine and obtain information from hospital accounting records, books, returns, reports and audited financial statements and reports thereon;

☐ appoint medical practitioners with the duty and power to examine and obtain information from medical and other hospital records, including patients' charts with medical records and nurses' notes, reports and accounts of patients who are receiving or have received insured services;

☐ appoint inspectors with the duty and power to inspect and examine books, accounts and records of employers and collectors to obtain information related to the hospital and insurance plan;

☐ withhold payment for insured services for any insured person who does not, in the opinion of the Minister, medically require such services;

☐ act as a central purchasing agent to purchase drugs, biologicals or related preparations for all hospitals in the province; to supervise, check and inspect the use of drugs, biologicals or related preparations by hospitals in the province and to withhold or reduce payments under the Act to a hospital that does not comply with Regulations relating to purchasing drugs, biologicals or related preparations; and

☐ supervise and ensure the efficient and economical use of all diagnostic or therapeutic aids and procedures used by or in hospitals and to withhold or reduce payments under the Act to a hospital that does not comply with the Regulations relating to using such aids and procedures.

The Health Ministry, through the Department, has the responsibility for the overall efficiency and effectiveness of the provincial health system.

Specifically, the Department is responsible for:

☐ setting overall directions and priorities;
☐ developing policies and strategies, legislation, provincial standards and measures;
☐ monitoring provincial health status;
☐ monitoring and ensuring that the Provincial Health Services Authority (PHSA) and the four Regional Health Authorities comply with Regulations and standards;
☐ evaluating the performance of the health system;
☐ allocating funds to the PHSA and the four Regional Health Authorities;
☐ improving the quality and management of a comprehensive province-wide health information system;
☐ ensuring access to high-quality health services;
☐ addressing emerging health issues and examining new technology before implementation; and
☐ directly administering certain services and programs.

The PHSA and four Regional Health Authorities are responsible for service delivery as allowed under the *Health and Community Services Act* (1993). The Authorities operate hospitals, health centres, manors and mental health facilities, and hire physicians, nurses and other health-related workers.

Their responsibilities include:

☐ assessing the health needs of residents in their regions;
☐ providing for the input and advice of their residents;
☐ allocating and managing resources, setting priorities, hiring staff and making the best use of available resources;
☐ consulting with other organizations involved in the health field;
☐ developing policies, standards and measures;
☐ planning and coordinating, with the Department and other Authorities, the delivery of the full range of health services;
☐ promoting health and wellness in their communities;
☐ making information available to residents on choices about health and health services;
☐ ensuring reasonable access to health services; and
☐ monitoring, evaluating and reporting on performance to residents and to the Ministry.

In December 2001, Prince Edward Island's health regions were awarded accredited status by the Canadian Council on Health Services Accreditation. The results of the accreditation process were announced following a comprehensive self-assessment process and surveys conducted in June 2001, by a team of 11 physicians and senior health administrators from across the country.

1.2 Reporting Relationship

An annual report is submitted by the Department to the Minister responsible and is tabled by the Minister in the Legislative Assembly. The Annual Report provides information on the operating principles of the Department and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions and statistical highlights for the year.

The PHSA and four Regional Health Authorities are required under section 24 of the *Health and Community Services Act* to submit an annual report in the fall to the Minister of Health and Social Services. The Minister has the authority to request other information, as deemed necessary, on the operations of the Regional Health Authorities and their delivery of health services in their areas of jurisdiction. Regional Health Authorities are required to hold annual public meetings at which information about their operations and the provision of health services is presented.

1.3 Audit of Accounts

The provincial Auditor General conducts annual audits of the Public Accounts of the Province of Prince Edward Island. The Public Accounts of the Province include the financial activities, revenues and expenditures of the Department.

Each Regional Health Authority has the responsibility to engage its own public accounting firm to conduct annual financial statement audits. The audited financial statements are provided to the Ministry and the Department of the Provincial Treasury. The reports are presented at public meetings held annually within each region. Audited statements are also presented to the Legislative Assembly and included within the published Public Accounts of the Province of Prince Edward Island.

The provincial auditor general, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program-specific basis with respect to the operations of the Department, as well as the PHSA and each of the four Regional Health Authorities.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in- and out-patient hospital services available at no charge to a person who is eligible. Insured hospital services include:

- ☐ necessary nursing services;
- ☐ laboratory;
- ☐ radiological and other diagnostic procedures;
- ☐ accommodations and meals at a standard ward rate;
- ☐ formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital;
- ☐ operating room, case room and anaesthetic facilities;
- ☐ routine surgical supplies; and
- ☐ radiotherapy and physiotherapy services performed in hospital.

As of March 2004, there were seven acute care facilities participating in the Province's insurance plan. In addition to 454 acute care beds, these facilities house 20 rehabilitative beds, 19 day-surgery beds, as defined under the *Hospitals Act* (1988), and seven insured chronic care beds.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act* (1988). Amendments were passed in 1996. Changes were made to include thephysician resource planning process.

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The number of practitioners who billed the Insurance Plan as of March 31, 2004, was 202.

Under section 10 of the *Health Services Payment Act*, a physician or practitioner who is not a participant in the Insurance Plan is not eligible to bill the Plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that physicians advise patients that they are not participating physicians or practitioners and provide the patient with sufficient information to enable recovery of the cost of services from the Minister of Health.

Under section 10.1 of the *Health Services Payment Act*, a participating physician or practitioner may determine, subject to and in accordance with the Regulations and in respect of a particular patient or a particular basic health service, to collect fees outside of the Plan or selectively opt out of the Plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2004, no physicians had opted out of the Health Care Insurance Plan.

Any basic health services rendered by physicians that are medically required are covered by the Health Care Insurance Plan. These include:

☐ most physicians' services in the office, at the hospital or in the patient's home;
☐ medically necessary surgical services, including the services of anaesthetists and surgical assistants where necessary;
☐ obstetrical services, including pre- and post-natal care, newborn care or any complications of pregnancy such as miscarriage or Caesarean section;
☐ certain oral surgery procedures performed by an oral surgeon when it is medically required, with prior approval that they be performed in a hospital;
☐ sterilization procedures, both female and male;
☐ treatment of fractures and dislocations; and
☐ certain insured specialist services, when properly referred by an attending physician.

New codes for MRI services, and several other codes, were developed through the negotiation process between the Department and the Medical Society of Prince Edward Island.

The process to add a physician service to the list of insured services involves negotiation between the Department and the Medical Society.

2.3 Insured Surgical-Dental Services

Dental services are not insured in the Health Care Insurance Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical- dental procedures included as basic health services in the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital or in an office with prior approval as confirmed by the attending physician.

A surgical-dental service (post operative removal of mandibular wires in an office setting) has been added as a result of negotiations between the Dental Association and the Department.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Provincial hospital services not covered by the Hospital Services Plan include:

☐ services that persons are eligible for under other provincial or federal legislation;
☐ mileage or travel, unless approved by the Department;
☐ advice or prescriptions by telephone, except anticoagulant therapy supervision;
☐ examinations required in connection with employment, insurance, education, etc.;
☐ group examinations, immunizations or inoculations, unless prior approval is received from the Department;
☐ preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;
☐ testimony in court;
☐ surgery for cosmetic purposes unless medically required;
☐ dental services other than those procedures included as basic health services;
☐ dressings, drugs, vaccines, biologicals and related materials;
☐ eyeglasses and special appliances;
☐ physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments;
☐ reversal of sterilization procedures;
☐ *in vitro* fertilization;
☐ services performed by another person when the supervising physician is not present or not available;

☐ services rendered by a physician to members of the physician's own household, unless approval is obtained from the Department; and

☐ any other services that the Department may, upon the recommendation of the negotiation process between the Department and the Medical Society, declare non-insured.

Provincial hospital services not covered by the Hospital Services Plan include private or special duty nursing at the patient's or family's request; preferred accommodation at the patient's request; hospital services rendered in connection with surgery purely for cosmetic reasons; personal conveniences, such as telephones and televisions; drugs, biologicals, and prosthetic and orthotic appliances for use after discharge from hospital; and dental extractions, except in cases where the patient must be admitted to hospital for medical reasons with prior approval of the Department.

The process to de-insure services by the Health Care Insurance Plan is done in collaboration with the Medical Society and the Department.

All Island residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Board of Prince Edward Island do not receive priority access to services through additional payment.

PEI has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Department to monitor usage and service concerns.

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act* and Regulations, section 3, define eligibility for the health care insurance plans. The plans are designed to provide coverage for eligible Prince Edward Island residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day in Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital and medical services on the first day of the third month following the month of arrival.

Residents who are ineligible for coverage under the health care insurance plan in Prince Edward Island are members of the Canadian Forces, Royal Canadian Mounted Police (RCMP), inmates of federal penitentiaries and those eligible for certain services under other government programs, such as Workers' Compensation or the Department of Veterans Affairs' programs.

Ineligible residents may become eligible in the following cases: members of the Canadian Forces, RCMP and penitentiary prisoners on discharge, release or release following the termination of rehabilitation leave. Where such is granted by the Canadian Forces, the province, where incarcerated or stationed at time of release or discharge, or the province where resident on completing rehabilitation leave as may be appropriate, will provide initial coverage for the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged parolees.

Foreign students, tourists, transients or visitors to Prince Edward Island do not qualify as residents of the province and are, therefore, not eligible for hospital and medical insurance benefits.

3.2 Registration Requirements

New or returning residents must apply for health coverage by completing a registration application from the Department. The application is reviewed to ensure that all necessary information is provided. A health card is issued and sent to the resident within two weeks. Renewal of coverage takes place every five years and residents are notified by mail six weeks before renewal.

The number of residents registered for the Health Care Insurance Plan in Prince Edward Island as of March 31, 2004, was 142,022.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward Island. There were 50 Kosovar refugees registered for Medicare as of March 31, 2004.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island are eligible for health insurance on the first day of the third month following the month of arrival in the province.

4.2 Coverage During Temporary Absences in Canada

Persons absent each year for winter vacations and similar situations involving regular absences must reside in Prince Edward Island for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the province, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

The term "temporarily absent" is defined as a period of absence from the province for up to 182 days in a 12-month period, where the absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the province under the above circumstances must notify the Registration Department before leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement.

The payment rate is $887 per day for hospital stays. The standard inter-provincial out-patient rate is $153. The methodology used to derive these rates is as if the patient had the services provided in Prince Edward Island.

4.3 Coverage During Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside Canada, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

Insured residents may be temporarily out of the country for a 12-month period one time only. Students attending a recognized learning institution in another country must provide proof of enrolment from the educational institution on an annual basis. Students must notify the Registration Department upon returning from outside the country.

For Prince Edward Island residents leaving the country for work purposes for longer than one year, coverage ends the day the person leaves.

For Island residents traveling outside Canada, coverage for emergency or sudden illness will be provided at Prince Edward Island rates only, in Canadian currency. Residents are responsible for paying the difference between the full amount charged and the amount paid by the Department.

The amount paid for insured emergency services outside Canada in 2003-2004 was $180,288.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency out-of-province medical or hospital services. Island residents seeking such required services may apply for prior approval through a Prince Edward Island physician. Full coverage may be provided for (Prince Edward Island-insured) non-emergency or elective services, provided the physician completes an application to the Department. Prior approval is required from the Medical Director of the Department to receive out-of-country hospital or medical services not available in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Both of Prince Edward Island's hospital and medical services insurance plans provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

5.2 Access to Insured Hospital Services

The construction of the new Prince County Hospital in Summerside continued in 2003-2004. The new facility was completed and occupied in April 2004.

Ambulance Services

The Department has renewed Agreements with each of the five private ambulance operators in the province to ensure the provision of emergency and non-emergency ground ambulance services on a 24-hour, seven day per week basis. The Department provides operating subsidies to operators who deliver service as per the requirements and standards contained within these agreements.

The Out of Province Medical Transport Support Program subsidizes the user fee for patients who require ground ambulance services to access specialized medical care outside the province.

Accessibility – New Initiatives

The Nurse Recruitment Strategy, announced in the 2000 Prince Edward Island Budget, has been revised and a number of new initiatives have been implemented. In addition to focusing on Registered Nurse recruitment, the strategy also looks at retention initiatives in Prince Edward Island. While the Nurse Recruitment Strategy addresses all sectors of health care, priority is given to the institutional sector, which covers acute and long-term care services. The Department is monitoring the results of the strategies.

Activity in the fourth year of the four-year Nursing Recruitment and Retention Strategy included:

- ☐ Summer Student Employment Program – 77 nursing students who completed their second or third year of a four-year Bachelor in Nursing Program gained additional clinical exposure to acute care and long-term care through this 12-week employment program.
- ☐ Student Sponsorships – 116 students, who at the beginning of the school year are entering their third or fourth year of a Bachelor in Nursing Program, received $2,400 in financial assistance.
- ☐ Refresher Program Cost Assistance – Tuition costs were reimbursed to two candidates who successfully completed a Nursing Refresher Course.
- ☐ Clinical Education Resources – Three new clinical educator positions were created.
- ☐ Enhanced Recruitment Resources – Relocation assistance was provided to 22 nurses who moved to Prince Edward Island.
- ☐ Work Force Development – Development of a planning strategy to manage emerging issues and to ensure current and future nurses develop competencies that match workplace requirements.
- ☐ In an effort to encourage more youth to consider careers in the health sector, the Health Care Futures – Public Sector program provided employment for 120 students in 2003 in a variety of settings including hospitals, government long-term care facilities and community care. In addition, the Health Care Futures – Private Sector program provided a 50 percent cost-sharing on the salary costs of students hired by the owners of private nursing homes and community care facilities.

There is also activity underway with Health Infostructure Atlantic to further develop an Electronic Health Record within Atlantic Canada. The major focuses of these activities include the overall Electronic Health Record, Health Surveillance and Telehealth activities.

5.3 Access to Insured Physician and Surgical-Dental Services

Physician services are accessible throughout the province except for specialties where there are vacancies.

Recruitment processes were undertaken for family physicians, anaesthetists, radiologists, radiation and medical oncologists, psychiatrists, and a pathologist and plastic surgeon.

The Primary Health Care Redesign project encourages physicians, nurses and other appropriate health care providers to work in collaborative group practices with shared responsibilities for client outcomes. In 2003-2004, five Family Health Centres operated in Charlottetown, Summerside, O'Leary, Hunter River/Rustico and Souris. These centres expanded family physician services to include primary health care nurses and other health professionals.

5.4 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and government to represent their interests in the process.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*.

Most physicians work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments. Alternate payment modalities are growing and seem to be the preference for new graduates.

5.5 Payments to Hospitals

The PHSA and four Regional Health Authorities are responsible for delivering hospital services in the province under the *Health and Community Services Act*. The financial (budgetary) requirements are established annually through consultation with the Department and are subject to approval by the Legislative Assembly through the annual budget process.

Payments (advances) to PHSA and the Regional Health Authorities for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

The usual funding method includes using a global budget adjusted annually to take into consideration increased costs related to such items as labour agreements, drugs, medical supplies and facility operations.

6.0 Recognition Given to Federal Transfers

The Government of Prince Edward Island acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2003-2004 Annual Budget and related budget documents and its 2002-2003 Public Accounts, which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

7.0 Extended Health Care Services

Extended health care services are not an insured service, except for the insured chronic care beds noted in section 2.1. Extended care services are provided through the four Regional Health Authorities of the Health and Social Services system.

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

Nursing home services are available on approval from regional admission and placement committees for placement into public manors and licensed private nursing homes. There are currently 18 long term care facilities in the province, nine public manors and nine licensed private nursing homes, with a total of 968 beds, including respite and temporary beds. Nursing home admission is for individuals who require 24-hour registered nurse (nursing care) supervision and care management. The standardized Seniors Assessment Screening Tool is used to determine service needs of residents for all admissions to nursing homes. Payment for long term care is the responsibility of the individual. When a resident of a facility or someone coming into a facility does not have the financial resources to pay for their own care, they can apply for financial assistance under the Social Assistance Act Regulations, Part II. The Province subsidizes 73 percent of residents in nursing homes. The federal government subsidizes approximately 7.5 percent of nursing home residents through Veterans Affairs Canada. The remaining 19.5 percent finance their own care.

In addition to nursing home facilities, there are 36 licensed community care facilities in Prince Edward Island. As of March 31, 2004, the total number of licensed community care facility beds was 951. A Community Care Facility is a privately operated licensed establishment with five or more residents. These facilities provide semi-dependent seniors and semi-dependent physically and mentally challenged adults with accommodation, housekeeping, supervision of daily living activities, meals and personal care assistance for grooming and hygiene. Care needs are assessed using the Seniors Assessment Screening Tool and are at Level 1, 2 or 3. Residents are eligible to apply for financial assistance under the *Social Assistance Act* Regulations, Part I. It should be noted that payment to community care is the responsibility of the individual. Clients lacking adequate financial resources may apply for financial assistance under the *Prince Edward Island Social Assistance Act.*

7.2 Home Care Services

Home Care and Support provides assessment and care planning to medically stable individuals, and defined groups of individuals with specialized needs, who without the support of the formal system, are at risk of being unable to stay in their own home, or are unable to return to their own home from a hospital or other care setting. Services provided through Home Care and Support include nursing, personal care, respite, occupational and physical therapies, adult protection, palliative care, home and community-based dialysis, assessment for nursing home placement and community support. The Senior's Assessment Screening Tool is used to determine the nature and type of service needed. Professional services in home care are currently provided at no cost to the client. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment, which is generally waived for palliative care clients.

7.3 Ambulatory Health Care Services

Prince Edward Island has public Adult Day Programs that provide services such as recreation, education and socialization for dependent elders. Individuals who require this service are assessed by regional Home Care staff. The overall purpose of adult day programs, is to allow clients to remain in their homes as long as possible, provide respite for care givers, monitor client's health and provide social interaction. There are Adult Day Programs in all four health regions.

The Prince Edward Island Dialysis Program is a community-based service that operates under the medical direction and supervision of the Nephrology team at the QEII Health Sciences Centre in Halifax.

There are five hemodialysis clinics in the province. This is a publically funded service. Prince Edward Island also offers a hemodialysis service to out-of-province/country visitors from the existing clinic locations. The provision of this service is based on the capacity within the clinics and the availability of human resources to provide this treatment at the time of the request. Cost of the service is covered through reciprocal billing if from another Canadian jurisdiction and by the visitor if from out of Canada.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#).	134,006	138,205	140,001	141,031	142,022

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#):					
a. acute care	7	7	7	7	7
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	7	7	7	7	7
3. Payments ($):					
a. acute care	104,000,000	106,774,200	109,128,000	115,697,000	121,944,000
b. chronic care	not applicable	not applicable	900	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	104,000,000	106,774,200	109,128,900	115,697,000	121,944,000
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
5. Number of insured hospital services provided (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
6. Payments ($):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	99	101	101	97	96
b. specialists	74	75	75	92	94
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	173	176	176	189	190
8. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
9. Number of not participating physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
10. Number of services provided through fee for service (#):					
a. general practitioners	848,816	861,112	816,197	716,597	783,632
b. specialists	415,130	409,917	358,600	362,619	397,916
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,263,946	1,271,029	1,174,797	1,079,216	1,181,548
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	15,700,000	15,800,000	16,588,900	16,537,250	16,234,598
b. specialists	17,100,000	17,200,000	15,559,600	16,446,970	17,054,737
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	32,800,000	33,000,000	32,148,500	32,984,220	33,289,335
12. Average payment per fee for service service ($):					
a. general practitioners	18.00	18.00	20.00	23.00	21.00
b. specialists	41.00	42.00	43.00	45.00	43.00
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	26.00	26.00	27.00	31.00	28.00
13. Number of services provided through all payment methods (#):					
a. medical	154,930	152,796	107,683	96,152	111,896
b. surgical	144,947	143,940	140,020	150,036	162,577
c. diagnostic	115,253	113,181	110,897	116,431	123,443
d. other	848,816	861,112	816,197 [1]	716,597 [1]	783,632 [1]
e. total	1,263,946	1,271,029	1,174,797	1,079,216	1,181,548
14. Total payments to physicians paid through all payment methods ($):					
a. medical	6,600,000	6,500,000	5,061,000	4,892,997	4,845,230
b. surgical	8,800,000	8,900,000	8,703,600	9,509,720	9,880,089
c. diagnostic	1,700,000	1,800,000	1,795,000	2,044,253	2,329,418
d. other	not applicable	15,800,000	16,588,900 [1]	16,537,250 [1]	16,234,598 [1]
e. total	32,800,000	33,000,000	32,148,500	32,984,220	33,289,335
15. Average payment per service, all payment methods ($):					
a. medical	43.00	43.00	47.00	51.00	43.00
b. surgical	61.00	62.00	62.00	63.00	61.00
c. diagnostic	15.00	15.00	16.00	18.00	19.00
d. other	not applicable	not applicable	20.00	23.00	21.00
e. all services	26.00	26.00	27.00	31.00	28.00

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004 [2]
16. Total number of claims, in-patient (#).	1,812	1,903	2,220	2,059	2,006
17. Total number of claims, out-patient (#).	14,428	14,839	17,572	16,790	15,638
18. Total payments, in-patient ($).	10,600,000	10,127,380	9,417,000	11,713,751	14,208,471
19. Total payments, out-patient ($).	2,300,000	2,380,567	2,930,100	2,879,064	2,578,895
20. Average payment, in-patient ($).	5,850.00	5,322.00	4,242.00	5,689.00	7,083.00
21. Average payment, out-patient ($).	160.00	160.00	167.00	171.00	165.00
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	56,084	46,832	67,435	48,369	45,255
23. Total payments ($).	3,080,000	3,370,102	3,871,900	3,778,171	3,795,244
24. Average payment per service ($).	55.00	72.00	57.00	78.00	84.00

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004 [2]
25. Total number of claims, in-patient (#).	21	30	26	23	37
26. Total number of claims, out-patient (#).	106	112	85	152	130
27. Total payments, in-patient ($).	53,800	54,180	123,127	79,577	155,922
28. Total payments, out-patient ($).	21,700	43,494	13,702	25,954	24,366
29. Average payment, in-patient ($).	2,561.00	1,806.00	4,736.00	3,459.00	4,214.00
30. Average payment, out-patient ($).	205.00	388.00	161.00	171.00	187.00
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	666	728	677	521	706
32. Total payments ($).	38,274	57,365	33,995	30,076	37,100
33. Average payment per service ($).	57.00	79.00	50.00	58.00	53.00

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	2	2	2	2	2
35. Number of services provided (#).	176	145	176	312	393
36. Total payments ($).	37,600	53,100	60,989	88,443	90,851
37. Average payment per service ($).	214.00	366.00	347.00	283.00	231.00

Endnotes

1. Includes general practitioners.
2. Figures may be subject to change for 03/04 as reciprocal billing arrangements allow a one year period for submissions of claims.

Nova Scotia

Introduction

The management of day-to-day health services delivery in Nova Scotia is the responsibility of the Province's nine District Health Authorities (DHAs). These DHAs were created under the *Health Authorities Act*, which came into effect on January 1, 2001. The passage of this Act brought Nova Scotia closer to its goal of developing an affordable, high-quality, sustainable health care system.

Under the *Health Authorities Act*, the DHAs are required to provide the Minister of Health with monthly and quarterly financial statements and audited year-end financial statements. They are also required to submit annual reports, which provide updates on implementing DHA business plans. These provisions ensure greater financial accountability. The sections of the *Health Authorities Act* related to financial reporting and business planning came into effect on April 1, 2001.

Pursuant to the *Provincial Finance Act* (2000) and government policies and guidelines, the Department of Health is required to release annual accountability reports outlining outcomes against its business plan for that fiscal year. The 2003-2004 accountability report will be available in late 2004.

Nova Scotia continues to be committed to the delivery of medically necessary services that are consistent with the principles of the *Canada Health Act*.

In March 2003, the Department of Health released a plan for better health care entitled, "Your Health Matters". This plan focuses on health promotion, more doctors and nurses, shorter wait lists, seniors' care and health services within communities. This report can be viewed at: **www.gov.ns.ca/health/your_health_matters.htm**

In March 2004, and as a follow-up to this report, the Department of Health released the report entitled "Ministers' Report to Nova Scotians: Confident Change for Quality Care". This report can be viewed at: **www.gov.ns.ca/health/report/default.htm**

Additional information related to health care in Nova Scotia may be obtained from the Department of Health Web site at: **www.gov.ns.ca/health**

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Two plans cover insured health services in Nova Scotia: the Hospital Insurance Plan (HSI) and the Medical Services Insurance Plan (MSI). The Department of Health administers the HSI Plan, which operates under the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35, passed by the Legislature in 1958.

The MSI is administered and operated on a non-profit basis by an authority consisting of the Department of Health and Atlantic Blue Cross Care, under the legislation previously mentioned (sections 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32 and 35).

Section 3 of the *Health Services and Insurance Act* states that subject to this Act and the Regulations, all residents of the province are entitled to receive insured hospital services from hospitals on uniform terms and conditions, and that all residents of the province are insured upon uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to, from time to time, enter into agreements and vary, amend or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

Atlantic Blue Cross Care, by virtue of the 1992 Memorandum of Agreement, is mandated to:

☐ determine the eligibility of providers participating in the Plan;

☐ plan and conduct information and education programs necessary to ensure that all persons and providers are informed of their entitlements and responsibilities under the Plan;

☐ make payments under the Plan for any claim or class of claims for insured health services for which the Province is liable; and

☐ develop an audit and assessment system of claims and payments, to maintain a continuous audit process and to establish any other administrative structures required to fulfill its mandate.

1.2 Reporting Relationship

Atlantic Blue Cross Care is required to submit to the Province, no later than the 20th day of each month, monthly expenditure reports, including such detail as determined by the Province. Within 30 days of the end of the fiscal quarter, Atlantic Blue Cross Care is required to provide a report that includes expenditures to the end of the quarter and a forecast of expenditures to the end of the year. Atlantic Blue Cross Care is required to provide minutes and any information necessary to keep the Province informed of all meetings, conferences, etc. that are charged to the MSI Plan. Reports prepared by Atlantic Blue Cross Care are forwarded to the respective Insured Program areas of the Department of Health for review and follow-up.

Section 17(1)(i) of the *Health Services and Insurance Act*, and sections 11(1) and 12(1) of the Hospital Insurance Regulations, which relate to this Act, set out the terms for reporting by hospitals and hospital boards to the Minister of Health, their annual budget estimates and their monthly reports of actual revenues and expenditures.

1.3 Audit of Accounts

The Auditor General's office audits all expenditures of the Department of Health, including Pharmacare, the provincial drug program. The Department of Health's internal auditors perform a financial audit of the administration contract at Atlantic Blue Cross Care. An external audit is also conducted for Atlantic Blue Cross Care, which includes the administrative contract. No official audit is performed on Medicare payments; however, this is being recommended by the Auditor General's office.

All Long-term Care facilities, Home Care and Home Support agencies are now required to provide the Department with annual audited financial statements.

Under section 34(5) of the *Health Authorities Act*, every hospital board is required to submit to the Minister of Health by July 1st each year, an audited financial statement for the preceding fiscal year.

The Report of the Auditor General of Nova Scotia, tabled on November 28, 2003, contained audits that are relevant to the *Canada Health Act*:

☐ IWK Health Centre;

☐ Long-term care; and

☐ Payments to physicians.

1.4 Designated Agency

Atlantic Blue Cross Care administers and has the authority to receive monies to pay physician accounts under a Memorandum of Agreement with the Department of Health. Atlantic Blue Cross Care receives written authorization from the Department for the physicians to whom it may make payments. The rates of pay and specific amounts depend on the physician contract negotiated between Doctors Nova Scotia and the

Department of Health.

There is no legislation governing the role of Atlantic Blue Cross Care. Atlantic Blue Cross Care abides by the terms and conditions of the 1992 contract and its payment mechanism. Under this contract, Atlantic Blue Cross Care is required to submit to the Province:

☐ annual audited financial statements;
☐ detailed line-by-line Full-Time Equivalent counts on budget requests for which the Department actually approves staffing levels;
☐ line-by-line budgets showing salary, benefits, travel, postage, etc.; and
☐ a copy of the annual report.

All Atlantic Blue Cross Care system development for MSI and Pharmacare is controlled through a joint committee. All MSI and Pharmacare transactions are subject to a review by the Office of the Auditor General.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Nine District Health Authorities (DHAs) and the IWK Health Centre (Women and Children's Tertiary Care Hospital) deliver insured hospital services to both in- and out-patients in Nova Scotia in a total of 35 facilities[1].

Accreditation is not mandatory, but all facilities are accredited at a facility or district level. The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35, passed by the Legislature in 1958. Hospital Insurance Regulations were made pursuant to the *Health Services and Insurance Act*.

In-patient services include:

☐ accommodation and meals at the standard ward level;
☐ necessary nursing services;
☐ laboratory, radiological and other diagnostic procedures;
☐ drugs, biologicals and related preparations, when administered in a hospital;
☐ routine surgical supplies;
☐ use of operating room, case room and anaesthetic facilities;
☐ use of radiotherapy and physiotherapy services, where available; and
☐ blood or therapeutic blood fractions.

Out-patient services include:

☐ laboratory and radiological examinations;
☐ diagnostic procedures involving the use of radio-pharmaceuticals;
☐ electroencephalographic examinations;
☐ use of occupational and physiotherapy facilities, where available;
☐ necessary nursing services;
☐ drugs, biologicals and related preparations;
☐ blood or therapeutic blood fractions;
☐ hospital services in connection with most minor medical and surgical procedures;
☐ day-patient diabetic care;
☐ services other than medical services provided by and within the Nova Scotia Hearing and Speech Clinic;
☐ ultrasonic diagnostic procedures;
☐ home parenterel nutrition; and
☐ haemodialysis and peritoneal dialysis.

In order to add a new hospital service to the list of insured hospital services, DHAs are required to submit a New and/or Expanded Program Proposal to the Department of Health. This process is carried out annually through the business planning process. A Department-developed process format is forwarded to the DHAs for their guidance. A Department working group reviews and prioritizes all requests received. Based on available funding, a number of top priorities may be approved by the Minister of Health.

---

[1] The number of facilities reported in other documents may differ from the 35 facilities reported here as a result of differences in defining for the term "facility".

2.2 Insured Physician Services

The legislation covering the provision of insured physician services in Nova Scotia is the *Health Services and Insurance Act*, sections 3(2), 5, 8, 13, 13A, 17(2), 22, 27-31, 35 and the Medical Services Insurance Regulations.

The *Health Services and Insurance Act* was amended in 2002-2003 to include section 13B stating that:
'Effective November 1, 2002, any agreement between a provider and a hospital, or predecessors to a hospital, stipulating compensation for the provision of insured professional services, for the provider undertaking to be on-call for the provision of such services or for the provider to relocate or maintain a presence in proximity to a hospital, excepting agreements to which the Minister and the Society are a party, is null and void and no compensation is payable pursuant to the agreement, including compensation otherwise payable for termination of the agreement."

Under the *Health Services and Insurance Act*, persons who can provide insured physician services include:

- general practitioners, who are persons who engage in the general practice of medicine;
- physicians, who are not specialists within the meaning of the clause; and
- specialists, who are physicians and are recognized as specialists by the appropriate licensing body of the jurisdiction in which he or she practises.

Physicians (general practitioner or specialist) must be licensed by the College of Physicians and Surgeons in Nova Scotia in order to be eligible to bill the MSI system. Dentists receiving payment under the MSI Plan must be registered with the Provincial Dental Board and be recognized as dentists. In 2003-2004, 2,116 physicians and 28 dentists were paid through the MSI Plan.

Physicians retain the ability to opt into or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing his or her billing number. Patients who pay the physician directly due to opting out are reimbursed for these services by MSI. As of March 31, 2004, no physicians had opted out.

Insured services are those medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern. There are no limitations on medically necessary insured services.

No new large-scale services were added to the list of insured physician services in 2003-2004. On a quarterly, ongoing basis, new specific fee codes are approved that represent either enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes to the list of insured physician services is accomplished through a committee structure. Physicians wishing to have a new fee code recognized or established must first present their cases to Doctors Nova Scotia, which puts a suggested value on the proposed new fee.

The proposal is then passed to the Joint Fee and Tariff Committee for review and approval. The Joint Committee is comprised of equal representation from Doctors Nova Scotia and the Department of Health. When approved by the Joint Fee Schedule Committee, the approved proposed new fee is forwarded to the Department of Health for final approval and Atlantic Blue Cross Care is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

Under the *Health Services and Insurance Act*, a dentist is defined as a person lawfully entitled to practise dentistry in a place where that person carries on such a practice.

To provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the

MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse his or her election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. As of March 31, 2003, no dentists had opted out. In 2003-2004, 36 dentists were paid through the MSI Plan for providing insured surgical-dental services.

Insured surgical-dental services must be provided in a health care facility. Insured services are listed in the Insured Dental Services Tariff Regulations. Services under this program are insured when the conditions of the patient are such that it is medically necessary for the procedure to be done in a hospital and the procedure is of a surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth and oral and maxillary facial surgery. Additions to the list of surgical-dental services that are insured are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health for the addition of a new procedure. The Department of Health, in consultation with specific experts in the field, renders the decision on whether or not the new procedure becomes an insured service.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:
preferred accommodation at the patient's request;
☐ telephones;
☐ televisions;
☐ drugs and biologicals ordered after discharge from hospital;
☐ cosmetic surgery;
☐ reversal of sterilization procedures;
☐ surgery for sex reassignment;
☐ in-vitro fertilization;
☐ procedures performed as part of clinical research trials;
☐ services such as gastric bypass for morbid obesity, breast reduction/augmentation and newborn circumcision, except because of medical necessity; and
☐ services not deemed medically necessary that are required by third parties, such as insurance companies.

Uninsured physician services include:
☐ those a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation;
☐ mileage, travelling or detention time;
☐ telephone advice or telephone renewal of prescriptions;
☐ examinations required by third parties;
☐ group immunizations or inoculations unless approved by the Department;
☐ preparation of certificates or reports;
☐ testimony in court;
☐ services in connection with an electrocardiogram, electromyogram or electroencephalogram, unless the physician is a specialist in the appropriate specialty;
☐ cosmetic surgery;
☐ acupuncture;
☐ reversal of sterilization; and
☐ in-vitro fertilization.

All residents of the province are entitled to services covered under the *Health Services and Insurance Act*. If enhanced goods and services, such as the foldable interocular lens or a fibreglass cast can be purchased, it is required to fully inform patients about the cost. They are not to be denied service based on their inability to pay. The Province provides alternatives to any of the enhanced goods and services.

The Department of Health also carefully reviews all patient complaints or public concerns that may indicate that the general principles of insured services are not being followed.

The de-insurance of insured physician services is accomplished through a negotiation process between Doctors Nova Scotia and Department of Health representatives, who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service are also de-insured. The same process applies to dental and hospital services. The last time there was any significant amount of de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the Hospital Insurance Regulations pursuant to section 17 of the *Health Services and Insurance Act.* All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI on the first day of the third month following the month of their arrival as permanent residents. Persons moving permanently to Nova Scotia from another country are eligible on the date of their arrival in the province, provided they are Canadian citizens or hold "Permanent Resident" status as defined by Citizenship and Immigration Canada.

Members of the Royal Canadian Mounted Police (RCMP), members of the Canadian Forces, federal inmates and members of the North Atlantic Treaty Organization (NATO) are ineligible for MSI coverage. When their status changes, they become eligible for provincial Medicare.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. Once eligibility has been determined, an application form is generated. The applicant (and spouse if applicable) must sign the form before it can be processed. The applicant must indicate on the application the name and mailing address of a witness. The witness must be a Nova Scotia resident who can confirm the information on the application. The applicant must include proof of Canadian citizenship or provide a copy of an acceptable immigration document.

When the application has been approved, health cards will be issued to each family member listed. Each health card number is unique and is issued for the lifetime of the applicant. Health cards expire every four years. The health card number also acts as the primary health record identifier for all health service encounters in Nova Scotia for the life of the recipient. Proof of eligibility for insured services is required before residents are eligible to receive insured services. Renewal notices are sent to most cardholders three months before the expiry date of the current health card. Upon return of a signed renewal notice, MSI will issue a new health card.

There is no legislation in Nova Scotia forcing residents of the province to apply for MSI. There may be residents of Nova Scotia who, therefore, are not members of the health insurance plan.

In 2003-2004, there were 956,820 residents registered with the health insurance plan.

3.3 Other Categories of Individual

The following persons may also be eligible for insured health care services in Nova Scotia, once they meet the specific eligibility criteria for their situations:

Immigrants: Persons moving from another country to live permanently in Nova Scotia, are eligible for health care on the date of arrival. They must possess a landed immigrant document. These individuals, formerly called "landed immigrants", are now referred to as "Permanent Residents".

Non-Canadians who are married to a Canadian citizen or a Permanent Resident, and Convention Refugees who have applied in Canada for Permanent Residence status are eligible for insured services as of the date of application for Permanent Resident status. Applicants must possess a letter from Citizenship and Immigration Canada verifying their status. A Convention Refugee is a person designated by the Immigration Refugee Board to have been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group or political opinion.

In 2003-2004, there were 19,345 Permanent Residents registered with the health care insurance plan.

Work Permits: Persons moving to Nova Scotia from outside the country who possess a work permit can apply for coverage on the date of arrival in Nova Scotia, providing they will be remaining in Nova Scotia for at least one full year. A declaration must be signed to confirm that the worker will not be outside Nova Scotia for more than 31 consecutive days, except in the course of employment. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia, which is indicated on their health cards. Each year a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons are granted coverage on the same basis.

In 2003-2004, there were 478 individuals with Employment Authorizations covered under the health care insurance plan.

Student Permits: Persons moving to Nova Scotia from another country, who possess a Student Authorization will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia. Each year, a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons will be granted coverage on the same basis, once the student has gained entitlement.

In 2003-2004, there were 687 individuals with Student Authorizations covered under the health care insurance plan.

Refugees: Refugees are eligible for MSI if they possess either an employment or student authorization, or if they have applied for Permanent Resident status. They are governed by the eligibility provisions for the type of immigration document that they possess.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory will normally be eligible for MSI on the first day of the third month following the month of their arrival as Permanent Residents.

4.2 Coverage During Temporary Absences in Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to portability of insured services.

Generally, the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months as per the Eligibility and Portability Agreement. Students who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution, may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide, to MSI, a letter obtained from the educational institution that verifies the student's attendance there in each year for which MSI coverage is requested.

Workers who leave Nova Scotia to seek employment elsewhere will still be covered by MSI for up to 12 months, provided they do not establish residence in another province, territory or country. Services provided to Nova Scotia residents in other provinces or territories are covered by reciprocal agreements. Nova Scotia participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement. Quebec is the only province that does not participate in the medical reciprocal agreement. Nova Scotia pays for services provided by Quebec physicians to Nova Scotia residents at Quebec rates if the services are insured in Nova Scotia. The majority of such claims are received directly from Quebec physicians. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amounts paid by the Plan in 2003-2004, for in- and out-patient hospital services received in other provinces and territories were: $15,859,930 for out-of-province, in-patient services and $4,303,236 for out-of-province, out-patient services. Nova Scotia pays the host province rates for insured services in all reciprocal-billing situations.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident meets eligibility requirements, out-of-country services will be paid, at a minimum, on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. Ordinarily, to be eligible for coverage, residents must not be outside the country for more than six months in a calendar year. In order to be covered, procedures of a non-emergency nature must have prior approval before they will be covered by MSI.

Students who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution outside Canada may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI, a letter obtained from the educational institution that verifies the student's attendance there in each year for which MSI coverage is requested.

Workers who leave Nova Scotia to seek employment elsewhere are still covered by MSI for up to 24 months, provided they do not establish residence in another country.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. The total amount spent in 2003-2004 for insured in-patient services provided outside Canada was $623,896.

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services outside the country. Application for prior approval is made to the Medical Director of the MSI Plan by a physician in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the province, or if it can be provided in another province or only out-of-country. The decision of the Medical Consultant is relayed to the patient's physician. The patient is then covered under the Reciprocal Billing Agreement for elective services in another province or territory. If approval is given to obtain service outside the country, the full cost of that service will be covered under MSI.

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions. There are no user charges or extra charges under either plan.

Nova Scotia continually reviews access situations across Canada to ensure that it is not falling behind. In areas where improvement is deemed necessary, depending on the Province's financial situation, extra funding is generally allocated to that area. The Department of Health accepted the recommendations of the Provincial Osteoporosis Committee report, which included placing new bone density units in Sydney and Yarmouth and operating the Truro unit at full capacity. These units will be fully operational in 2004-2005. In March 2003, MRI services were introduced at the Cape Breton Regional Hospital to increase access and reduce provincial wait times.

In fiscal year 2004-2005, $7 million will be added to the Capital District budget to address the issue of ever-increasing orthopedic wait lists.

In February 2004, the Department of Health announced the hiring of a French language health services coordinator to develop a plan to improve access to health care services for French-speaking Nova Scotians.

5.2 Access to Insured Hospital Services

The Government of Nova Scotia continues to emphasize the provision of sustainable, quality health care services to its citizens.

In 2003-2004, a total of $9.8 million was provided to train, recruit and retain nurses. Eighty-three percent of the nurses from the class of 2003 renewed their licenses, compared with only 51 percent in 2001. This is the highest retention ratio since 1999.

In November 2003, the Minister of Health launched a new Web site for nurses and nursing students. This new Web site, which was designed by nurses, provides information on training, retraining, retaining and recruitment for nurses in Nova Scotia.

In January 2004, the Minister of Health announced funding to open 25 surgical beds and an additional operating room in the QEII Health Sciences Centre in Halifax. This will help ease the pressure on hospital wait times and emergency room overcrowding.

Table 1 provides a breakdown of key health professionals who are licensed to practice in Nova Scotia. Not all of these health professionals were actively involved in delivering insured health services.

Table 1:
Health Personnel in Nova Scotia (2002)

Health Occupation	Registered/ Licensed to Practice[2]
Physicians	2,045
Dentists[3]	464
Registered Nurses	9,556[4]
Licensed Practical Nurses	3,329[4]
Medical Radiation Technologists	483
Respiratory Therapists	186
Pharmacists	1,004
Occupational Therapists	240
Speech-Language Pathologists	156
Chiropractors	74
Opticians	173
Optometrists	76
Dentists	55
Dietitians	402
Psychologists	371

---

[2] Not all professionals licensed to practice actually work.

[3] A limited number of licensed dentists are approved for insured dental services.

[4] Data is for 2003.

In Nova Scotia in 2003-2004, Telehealth was also used to provide the services listed in Table 2.

Table 2:
Telehealth Services in Nova Scotia

Type of Health Event	Number of "Events"
Tele-radiology Cases	67
Education Sessions (attending sites)	763 (3,442)
Clinical Consultations	1,823
Administrative Meetings (attending sites)	378 (988)
Clinical Case Conferences	71

5.3 Access to Insured Physician and Surgical-Dental Services

In 2003-2004, 2,116 physicians and 28 dentists actively provided insured services under the Canada Health Act or provincial legislation. Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

The Province has increased the capacity for medical education, coordinates ongoing recruitment activities and has provided funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the province.

5.4 Physician Compensation

The Health Services and Insurance Act RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between Doctors Nova Scotia and the Nova Scotia Department of Health. Doctors Nova Scotia is recognized as the sole bargaining agent in support of physicians in the province. When negotiations take place, representatives from Doctors Nova Scotia and the Department of Health negotiate the total funding and other terms and conditions. The current master agreement is effective from April 1, 2004 through March 31, 2008. The agreement lays out what the medical services unit value will be for physician services and addresses other issues such as Canadian Medical Protective Association, membership benefits, emergency department payment, on-call funding, specific fee adjustments, dispute resolution processes, and other process or consultation issues.

Fee-for-service is still the most prevalent method of payment for physician services. However, there has been significant growth in the number of alternative funding arrangements in place in Nova Scotia

In 2003-2004, total payments to physicians for insured services in Nova Scotia was $434,000,386. The Department paid an additional $5,747,516 for insured physician services provided to Nova Scotia residents outside the province, but within Canada.

Payment rates for dental services in the province are negotiated between the Department of Health and the Dental Association of Nova Scotia and follow a process similar to physician negotiations. Dentists are paid on a fee-for-service basis. The current agreement expires on March 31, 2004.

5.5 Payments to Hospitals

The Department of Health establishes budget targets for health care services. It does this by receiving business plans from the nine DHAs, the IWK Health Centre and other non-DHA organizations. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The Health Authorities Act was given Royal Assent on June 8, 2000. The Act instituted the nine DHAs that replaced the former regional health boards. This change came into effect in

January 2001, under the District Health Authorities General Regulations. The implementation of community health boards under the Community Health Boards' Member Selection Regulations was effective in April 2001. The DHAs are responsible (section 20 of the Act) for overseeing the delivery of health services in their districts and are fully accountable for explaining their decisions on the community health plans through their business plan submissions to the Department of Health.

Section 10 of the *Health Services and Insurance Act* and sections 9 through 13 of the Hospital Insurance Regulations define the terms for payments by the Minister of Health to hospitals for insured hospital services.

In 2003-2004, there were 2,850 hospital beds in Nova Scotia (3.05 beds per 1,000 population). Department of Health direct expenditures for insured hospital services operating costs were increased to $1.095 billion. Total separations from all hospitals are unavailable at this time.

6.0 Recognition Given to Federal Transfers

In Nova Scotia, the *Health Services and Insurance Act* RS Chapter 197 acknowledges the federal contribution regarding the cost of insured hospital services and insured health services provided to provincial residents. The residents of Nova Scotia are aware, through press releases and media coverage of ongoing negotiations between the provinces and the federal government that Canada Health and Social Transfer (CHST) funding partially helps provide insured medical services in the province.

The Government of Nova Scotia also recognized the federal contribution under the CHST in various published documents including the following documents released in 2003-2004:

☐ Public Accounts 2003-2004; and
☐ Budget Estimates 2003-2004 and 2004-2005.

7.0 Extended Health Care Services

Home Care Services

Broad-based, provincially funded home care services were introduced in Nova Scotia in 1995. Home care is part of the continuum of services available through the Department of Health's Continuing Care Branch. Home care services are available to Nova Scotians of all ages and help individuals reach and maintain their maximum level of health and prolong independent community living. Home care can be provided to people who are chronically ill, disabled, convalescent or to individuals with an acute illness. Services can delay admissions to long-term care facilities or hospitals as well as facilitate early release from an acute care facility. The health care and support services available to individuals in the community through home care include nursing care, assistance with personal care, aid with home support activities, home oxygen services and respite. Both chronic services over the longer term and short-term acute services are provided through home care. Home care services in Nova Scotia continue to mature and, as resources allow, additional services will be added in the future. These may include services such as occupational therapy, physiotherapy, palliative care, pediatric services and others as deemed necessary.

The Nova Scotia Department of Health has implemented a Single Entry Access to its Continuing Care services. Nova Scotians connect with home care, long-term care placement and adult protection services through a single toll-free number.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#).	944,487	947,963	953,385	955,475	956,820

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#):					
a. acute care	35	35	35	35	35
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	35	35	35	35	35
3. Payments ($): [1]					
a. acute care	812,776,800	877,019,426	926,797,569	1,021,934,504	1,095,584,706
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	812,776,800	877,019,426	926,797,569	1,021,934,504	1,095,584,706
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	1	1	1	1	1
b. diagnostic imaging facilities	0	0	0	0	0
c. total	1	1	1	1	1
5. Number of insured hospital services provided (#):					
a. surgical facilities	120	109	81	83	38
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	38
6. Payments ($):					
a. surgical facilities	15,677	14,627	10,926	11,714	5,531
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	5,531

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	829	920	865	875	904
b. specialists	1,095	1,067	1,128	1,142	1,198
c. other	0	0	10	9	14
d. total	1,924	1,987	2,003	2,026	2,116
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	4,619,083	4,498,232	4,521,991	4,563,449	4,629,753
b. specialists	1,606,842	1,645,535	1,650,685	1,677,973	1,924,079
c. other	0	3,951	2,999	2,512	7,098
d. total	6,225,925	6,147,718	6,175,675	6,243,934	6,560,930
11. Total payments to physicians paid through fee for service ($): [2]					
a. general practitioners	104,587,110	102,332,556	102,555,964	113,507,874	120,455,816
b. specialists	112,250,617	117,891,477	118,414,434	127,688,914	133,964,947
c. other	0	175,890	162,779	165,984	250,201
d. total	216,837,727	220,399,923	221,133,176	241,362,772	254,670,965
12. Average payment per fee for service service ($):					
a. general practitioners	22.64	22.75	22.68	24.87	26.02
b. specialists	69.86	71.64	71.74	76.10	69.63
c. other	0.00	44.52	54.28	66.08	35.25
d. all services	34.83	35.85	35.81	38.66	38.82
13. Number of services provided through all payment methods (#): [3]					
a. medical	5,908,054	5,457,153	5,462,682	6,458,299	6,572,716
b. surgical	317,871	985,321	1,009,997	1,096,509	1,117,739
c. diagnostic	1,514,011	1,121,296	1,124,792	1,144,383	1,191,588
d. other	0	291,352	308,326	324,081	317,419
e. total	7,739,936	6,147,718	7,905,797	9,023,272	9,199,462
14. Total payments to physicians paid through all payment methods ($): [2 3]					
a. medical	not available	239,036,017	244,049,190	270,161,897	293,468,260
b. surgical	not available	77,328,861	80,867,051	91,426,158	96,065,557
c. diagnostic	not available	25,385,064	26,262,276	28,530,589	37,191,400
d. other	not available	7,287,248	8,015,345	8,210,021	7,275,169
e. total	350,091,235	349,037,190	359,193,862	398,328,665	434,000,386
15. Average payment per service, all payment methods ($): [3]					
a. medical	not available	29.40	29.18	41.83	44.65
b. surgical	not available	68.53	68.49	83.38	85.95
c. diagnostic	not available	57.21	58.97	24.93	31.21
d. other	not available	47.78	53.58	25.33	22.92
e. all services	45.23	35.85	35.81	44.14	47.18

Insured Services Provided to Residents in Another Province or Territory

Hospitals	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
16. Total number of claims, in-patient (#).	2,382	2,520	2,050	2,300	2,368
17. Total number of claims, out-patient (#).	30,086	32,859	30,749	34,425	32,968
18. Total payments, in-patient ($).	10,499,281	9,961,995	8,536,691	12,685,659	15,859,930
19. Total payments, out-patient ($).	3,772,315	4,171,365	4,009,667	4,447,816	4,303,236
20. Average payment, in-patient ($).	4,407.75	3,953.17	4,115.45	5,515.50	6,697.61
21. Average payment, out-patient ($).	125.38	126.94	130.39	129.20	130.58
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	not available	180,299	179,833	187,390	180,897
23. Total payments ($).	not available	4,766,189	5,078,794	5,562,125	5,747,516
24. Average payment per service ($).	not available	26.43	28.24	29.68	31.77

Insured Services Provided Outside Canada

Hospitals	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
25. Total number of claims, in-patient (#).	not available	not available	not available	not available	not available
26. Total number of claims, out-patient (#).	not applicable	not applicable	not applicable	not applicable	not applicable
27. Total payments, in-patient ($).	1,053,577	735,834	1,000,023	938,092	623,896
28. Total payments, out-patient ($).	not applicable	not applicable	not applicable	not applicable	not applicable
29. Average payment, in-patient ($).	not available	not available	not available	not available	not available
30. Average payment, out-patient ($).	not applicable	not applicable	not applicable	not applicable	not applicable
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	not available	2,541	2,421	2,748	2,667
32. Total payments ($).	not available	98,461	109,484	121,780	120,977
33. Average payment per service ($).	not available	38.75	45.22	44.32	45.36

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
34. Number of particpating dentists (#).	55	39	35	36	28
35. Number of services provided (#).	17,525	6,853	4,497	5,188	3,780
36. Total payments ($).	1,467,485	998,692	884,506	939,004	904,283
37. Average payment per service ($).	83.74	144.27	196.69	181.00	239.23

Endnotes

1. $'s are paid to acute care facilities/DHAs only.
2. Discrepancies may exist between data presented here and the Nova Scotia Annual Statistical Tables due to methodological differences.
3. Fee- for- service + alternate funded programs.

New Brunswick

Introduction

New Brunswick's ongoing commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility in health care services – the principles that form the foundation of the *Canada Health Act* – was reaffirmed in a number of ways during the 2003-2004 fiscal year.

During the year, the Province took action to make health care more accessible investing in new health facilities and medical equipment and enhanced accountability through reports to its citizens, the introduction of directly elected trustees to oversee the management of the province's regional health authorities.

Primary Health Care

The Province embarked on a new course toward community-based, patient-focused primary health care during 2003-2004 with the establishment of its first Collaborative Care Practice. This facility, located in the Devon-Marysville section of Fredericton, operates seven days a week with a group of physicians and nurses who work together to care for their patients. The practice has helped address primary health care needs in the Fredericton area and reduced demand on hospital emergency services. Pilot projects for collaborative practices involving individual physicians were also established in Bathurst, Moncton and Edmundston.

During the year, the Province also moved ahead to establish its first Community Health Centres (CHCs). These facilities offer a new approach to primary health care, with physicians working collaboratively with nurses, nurse practitioners and other health care providers to serve community health needs.

The first four CHCs have been established in Saint John, Minto, Doaktown and Lameque. Community health needs assessments, to determine the health care needs of the community and the mix of health professionals to be located at each centre, have been conducted. During the year, the Province announced that three more CHCs would be established to serve Plaster Rock, Riverside-Albert and Caraquet. This brings the total number of CHCs operating in the province to seven.

Nurse Practitioners

New Brunswick introduced nurse practitioners to the Province during the 2002-2003 fiscal year as part of an overall strategy to enhance access to primary care. Nurse practitioners are now at work in physician's offices, collaborative practice sites and at Community Health Centres around the province. In order to increase the supply of these new health professionals, the Minister of Health and Wellness announced on March 4, 2004 that education subsidies would be advanced to students studying to become nurse practitioners. The subsidy assisted 21 student nurse practitioners at three institutions during the 2003-2004 fiscal year.

Regional Health Authorities

The *Regional Health Authorities Act*, which provides for the delivery and administration of health services within specified geographic regions of the province, came into force on April 1, 2002. The eight Regional Health Authorities (RHAs) are responsible for managing and delivering acute care hospital services, extra-mural services and addictions services.

The Minister of Health and Wellness appointed members to serve on the eight new boards for terms of two to four years. With the expiry of the two-year terms in May 2004, eight members of each RHA board were elected by the voters of each health region in conjunction with scheduled municipal and school board elections. The Minister continues to appoint the seven remaining members of each 15-member board.

To further enhance the role of RHAs and accountability for health services to New Brunswickers, legislation was introduced to transfer responsibility for delivering public health and mental health services from the Department of Health and Wellness to RHAs. This transfer will be completed during the 2004- 2005 fiscal year.

Health Human Resources Study

On February 2, 2002, the Minister of Health and Wellness released a study commissioned by the Department to determine New Brunswick's current and future supply and demand for major health-related occupations.

The study, conducted by Fujitsu Consulting, analyzed supply and demand in key health disciplines to identify future gaps, major issues and trends in health human resources. The first phase of the report focused on 27 health-related professions, while the second phase examined the situation related to physicians. Health care provider groups were major contributors to the study. The report recommends strategies to help New Brunswick meet its future health human resources requirements, and thereby assure that New Brunswickers continue to have appropriate access to insured health services.

Health Charter of Rights and Responsibilities

The Minister of Health and Wellness introduced the *Health Charter of Rights and Responsibilities Act* was introduced in the Legislature on April 8, 2003. The Act ensures that all New Brunswickers have a right to timely access to health care services; to safe, comfortable and considerate treatment; to take informed health care decisions; and to have their complaints investigated. The Act confirms that New Brunswickers have a responsibility to use health care services responsibly; to learn about and make healthy lifestyle choices; to participate actively in decisions regarding their health care; and to use complaint mechanisms appropriately and effectively. The Act would also establish a Health and Wellness Advocate, reporting directly to the Legislative Assembly, to help New Brunswickers deal with the health care system. Following Second Reading, the Act was referred to the Select Committee on Health Care for further study.

Reporting To Our Citizens

The Province also continues to take action to make New Brunswickers better informed on the state of their own health and the status of their health care system.

In September 2002, New Brunswick joined with other jurisdictions in reporting to its population on a set of common health indicators, as agreed to by the First Ministers in September 2000. The report showed that New Brunswickers have a high rate of satisfaction with the health services they receive, but performed relatively poorly on measures related to personal health. New Brunswick, along with other jurisdictions will issue a follow-up report on health indicators in November 2004.

In January 2003, the Province released the first New Brunswick Health Care Report Card, reporting to the province's citizens on the status of health care services and the overall health of New Brunswickers. The report examined key determinants of health within the province's population and considered the challenges that face New Brunswickers in sustaining the health care services they have come to cherish. The Department of Health and Wellness will issue a follow-up report during the 2004-2005 fiscal year.

Other Developments

On March 31, 2004, the Minister of Health and Wellness tabled amendments to the *Medical Services Payment Act* to clarify eligibility for health services provided in the State of Maine. The Act was amended to allow health facilities in the neighbouring jurisidiction in the United States to provide insured services to people working and visiting, as well as residing, in proscribed geographic regions in New Brunswick. The amended legislation received Royal Assent on May 28, 2004.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick, the health care insurance plan is known as the Medical Services Plan. The public authority responsible for operating and administering the plan is the Minister of Health and Wellness, whose authority rests under the *Medical Services Payment Act* and its Regulations, which were proclaimed on January 1, 1971.

The Act and Regulations specify eligibility criteria, the rights of the beneficiary and the responsibilities of the provincial authority, including the establishment of a medical service plan, the insured and the uninsured services. The legislation also stipulates the type of agreements the provincial authority may enter into with provinces and territories and with the New Brunswick Medical Society. As well, it specifies the rights of a medical practitioner, how the amounts to be paid for entitled services will be determined, how assessment of accounts for entitled services may be made and confidentiality and privacy issues as they relate to the administration of the Act.

The Minister of Health and Wellness is responsible for establishing a medical services plan that identifies beneficiaries, which services are and are not covered, and the amounts to be paid for entitled services. Under the Plan, the Minister assesses and audits physician billings through inspectors appointed by him or her and through a professional review committee as defined in sections 24(1) to 33 of the Medical *Services Payment Act* and Regulations. The Minister also has the authority to recover the cost of entitled services from a person who is negligent.

1.2 Reporting Relationship

The Medicare Branch of the Department of Health and Wellness has a mandate to administer the Medical Services Plan. The Minister reports to the Legislative Assembly through the Department's annual report and through regular legislative processes.

The *Regional Health Authorities Act*, which came into force on April 1, 2002, sets out the relationship between the eight Regional Health Authorities (RHAs) and the Department of Health and Wellness. Under the Act, RHAs must prepare regional health and business plans that are in harmony with the provincial health plan developed by the Department of Health and Wellness. The business and affairs of the RHA are to be controlled and managed by a board of directors, appointed or elected in accordance with the Act and its regulations. The chief executive officer of each RHA reports to the Deputy Minister of Health and Wellness. Under sections 7(1) and 7(2) of the Act, the Minister of Health and Wellness shall establish an accountability framework, drafted in consultation with RHAs, to specify the responsibilities that each party has to the other in the provincial health system.

1.3 Audit of Accounts

Three groups have a mandate to audit the Medical Services Plan.

The Auditor-General of New Brunswick

In accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which includes the financial records of the Department of Health and Wellness. For 2003-2004, all transactions of the Department were subject to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report to identify errors and control weaknesses. The Auditor General also conducts management reviews on programs as he or she sees fit. During 2003-2004, the Auditor General reported on the accountability of psychiatric hospitals and psychiatric units.

The Office of the Comptroller

The Comptroller is the chief internal auditor for the Province of New Brunswick and conducts internal audits in accordance with responsibilities and authority set out in the Financial Administration Act. The objective of an internal audit is to fulfill the Comptroller's mandate as it relates to the Appropriations Audit, Information Systems Audit, Statutory Audits and Value-For-Money Audits. The audit work performed by the Office varies, depending on the nature of the entity audited. During 2003-2004, the Office of the Comptroller continued to gather risk assessment data on a number of programs offered by the Department of Health and Wellness. The Comptroller also undertook a review of inventory systems and procedures, and a Harmonized Sales Tax (HST) recovery project in the Department of Health and Wellness and other selected departments.

Department of Health and Wellness Internal Audit

The Department's Internal Audit Group was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The unit performs program audits to report on the effectiveness of programs in meeting departmental objectives. For 2003-2004, the Internal Audit reviewed aspects of the Medical Education Training Program, the physician salaries component of Medicare and completed a risk assessment and service review on the Serum Depot component of the Department's Epidemiology Program.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes the *Hospital Services Act*, 1973, and section 9 of Regulation 84-167 and the *Hospital Act*, assented to on May 20, 1992, and its Regulation 92-84.

There are eight RHAs, established under the authority of the *Regional Health Authorities Act*. Each RHA includes a regional hospital facility and a number of smaller facilities, all of which provide insured services for both in- and out-patients. Each RHA has other health facilities or health centres, without designated beds, that provide a range of services to entitled persons.

Under Regulation 84-167 of the *Hospital Services Act*, New Brunswick residents are entitled to the following insured hospital services:

- In-patient services in a hospital facility operated by an approved regional health authority as follows:
    - accommodation and meals at the standard ward level,
    - necessary nursing service,
    - laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability,
    - drugs, biologicals and related preparations, as provided for under Schedule 2,
    - use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
    - routine surgical supplies,
    - use of radiotherapy facilities, where available,
    - use of physiotherapy facilities, where available, and
    - services rendered by persons who receive remuneration therefore from the regional health authority.

- ☐ Out-patient services in a hospital facility operated by an approved regional health authority as follows:
    - ☐ laboratory and diagnostic procedures, together with the necessary interpretations, when referred by a medical practitioner or nurse practitioner, when approved facilities are available,
    - ☐ laboratory and diagnostic procedures, together with the necessary interpretations, where approved facilities are available, when performed for the purpose of a mammography screening service that has been approved by the Minister of Health and Wellness,
    - ☐ the hospital component of available out-patient services when prescribed by a medical practitioner or nurse practitioner and provided in an out-patient facility of an approved regional health authority for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability, excluding the following services:
        - the provision of any proprietary medicines;
        - the provision of medications for the patient to take home;
        - diagnostic services performed to satisfy the requirements of third parties, such as employers and insurance companies;
        - visits solely for the administration of drugs, vaccines, sera or biological products;
        - any out-patient service which is an entitled service under the *Medical Services Payment Act*.

2.2 Insured Physician Services

The enabling legislation providing for insured physician services is the *Medical Services Payment Act*.

The Act was given Royal Assent on December 6, 1968. Regulation 84-29 was filed on February 13, 1984. Regulation 93-143 was filed on July 26, 1993. Regulation 96-113 was filed on November 29, 1996 and Schedule 4 (surgical-dental services) Regulation 84-20 was filed on April 13, 1999.

No changes to this Act and Regulations were introduced during 2003-2004.

The New Brunswick Medical Services Plan covers physicians who provide medically required services. The conditions that a physician must meet to participate in the New Brunswick Medical Services Plan are:

- ☐ to maintain current registration with the New Brunswick College of Physicians and Surgeons;
- ☐ to maintain membership in the New Brunswick Medical Society;
- ☐ to hold privileges in a RHA; and
- ☐ to have signed the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's Medical Services Plan as of March 31, 2004, was 1,496.

Physicians in New Brunswick have the option to opt out totally or for selected services. Opted-out practitioners are not paid directly by Medicare for the services they render and must bill patients directly in all cases. Patients are not entitled to reimbursement from Medicare.

The opting-out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. Opted-in physicians wishing to opt out for a service must first obtain the patient's agreement to be treated on an opted-out basis, after which they may bill the patient directly for the service. In these cases, the following procedure must be adhered to in every instance. The physician must advise the patient in advance and:

- ☐ the charges must not exceed the Medicare tariff. The practitioner must complete the specified Medicare claim forms and indicate the exact total amount charged to the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and by forwarding the claim form to Medicare.

- If the charges will be in excess of the Medicare tariff, the practitioner must inform the beneficiary before rendering the service that:
  - they are opting out and charging fees above the Medicare tariff;
  - in accepting service under these conditions, the beneficiary waives all rights to Medicare reimbursement; and
  - the patient is entitled to seek services from another practitioner who participates in the Medical Services Plan.

The physician must obtain a signed waiver from the patient on the specified form and forward that form to Medicare.

As of March 31, 2004, no physicians rendering health care services had elected to completely opt out of the New Brunswick Medical Services Plan.

The range of entitled services under Medicare includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed by a physician or a dental surgeon in a hospital facility.

An individual, a physician or the Department of Health and Wellness may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department of Health and Wellness. The decision to add a new service is usually based on conformity to "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and Canada. Considerations under the term "medically necessary" include services required for maintaining health, preventing disease and/or diagnosing or treating an injury, illness or disability. No public consultation process is used.

2.3 Insured Surgical-Dental Services

Schedule 4 of Regulation 84-20 (filed June 23, 1998, under the *Medical Services Payment Act*) identifies the insured surgical-dental services that can be provided by a qualified dental practitioner in a hospital, if the condition of the patient requires services to be rendered in a hospital. In addition, a general dental practitioner may be paid to assist another dentist for medically required services under some conditions.

The conditions a dental practitioner must meet to participate in the medical plan are maintaining current registration with the New Brunswick Dental Society and completing the Participating Physician's Agreement (included in the New Brunswick Medicare Dental registration form).

As of March 31, 2004, there were 14 dentists registered with the plan.

Dentists have the same opting-out provision as previously explained for physicians and must follow the same guidelines. The Department of Health and Wellness has no data for the number of non-enrolled dental practitioners in New Brunswick.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include the following:

- patent medicines;
- take-home drugs;
- third-party requests for diagnostic services;
- visits to administer drugs, vaccines, sera or biological products;
- televisions and telephones;
- preferred accommodation at the patient's request; and
- hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act*.

Services are not insured if provided to those entitled under other statutes.

There are no specific policies or guidelines, other than the Act and Regulations, to ensure that charges for uninsured medical goods and services (i.e. enhanced medical goods and services such as intra-ocular lenses, fibreglass casts, etc.), provided in conjunction with an insured health service, do not compromise reasonable access to insured services.

Uninsured Physician and Surgical-Dental Services

The services listed in Schedule 2 of New Brunswick Regulation 84-20 under the *Medical Services Payment Act* are specifically excluded from the range of entitled services under Medicare, namely:

☐ elective surgery or other services for cosmetic purposes;
☐ correction of inverted nipple;
☐ breast augmentation;
☐ otoplasty for persons over the age of 18;
☐ removal of minor skin lesions, except where the lesions are, or are suspected to be, pre-cancerous;
☐ abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;
☐ surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract itself, due to the existence of an illness or other complication;
☐ medicines, drugs, materials, surgical supplies or prosthetic devices;
☐ vaccines, serums, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the Health Act;
☐ advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;
☐ examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;
☐ dental services provided by a medical practitioner;
☐ services that are generally accepted within New Brunswick as experimental or that are provided as applied research;
☐ services that are provided in conjunction with, or in relation to, the services referred to above;
☐ testimony in a court or before any other tribunal;
☐ immunization, examinations or certificates for the purpose of travel, employment, emigration, insurance, or at the request of any third party;
☐ services provided by medical practitioners to members of their immediate family;
☐ psychoanalysis;
☐ electrocardiogram (ECG) where not performed by a specialist in internal medicine or paediatrics;
☐ laboratory procedures not included as part of an examination or consultation fee;
☐ refractions;
☐ services provided within the province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;
☐ the fitting and supplying of eyeglasses or contact lenses;
☐ transsexual surgery;
☐ radiology services provided in the province by a private radiology clinic;
☐ acupuncture;
☐ complete medical examinations when performed for the purposes of a periodic check-up and not for medically necessary purposes;
☐ circumcision of the newborn;
☐ reversal of vasectomies;
☐ second and subsequent injections for impotence;
☐ reversal of tubal ligations;
☐ intrauterine insemination;
☐ gastric stapling or gastric by-pass; and
☐ venipuncture for the purposes of the taking of blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility.

Dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services.

The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of "medically necessary," a review of medical service plans across the country and the previous use of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the government may not make any change to the Regulation until the advice and recommendations of the New Brunswick Medical Society is received or until the period within which the Society was requested by the Minister of Health and Wellness to furnish advice and make recommendations has expired. Subsequent to receiving their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation process is used.

No medical or surgical-dental services were removed from the insured service list in 2003-2004.

3.0 Universality

3.1 Eligibility

Sections 3 and 4 of the *Medical Services Payment Act* and its Regulation 84-20, define eligibility for the health care insurance plan in New Brunswick.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status or a valid Canadian immigration document. A resident is defined as a person lawfully entitled to be, or to remain, in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient or visitor to the province.

All persons entering or returning to New Brunswick (excluding children adopted from outside of Canada) have a waiting period before becoming eligible for Medicare coverage. Coverage commences on the first day of the third month following the month of arrival.

Residents who are ineligible for Medicare coverage include:

- regular members of the Canadian Armed Forces;
- members of the Royal Canadian Mounted Police (RCMP);
- inmates of federal prisons;
- persons moving to New Brunswick as temporary residents;
- a family member who moves from another province to New Brunswick before other family members move;
- persons who have entered New Brunswick from another province for the purpose of furthering their education and who are eligible to receive coverage under the medical services plan of that province; and
- non-Canadians who are issued certain types of Canadian authorization permits (e.g., a Student Authorization).

Provisions to become eligible for Medicare coverage include:

- non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to, or in a common-law relationship with, an eligible New Brunswick resident.

Provisions when status changes include:

- persons who have been discharged or released from the Canadian Armed Forces, the RCMP or a federal penitentiary. Provided that they are residing in New Brunswick at the time, these persons are eligible for coverage on the date of their release. They must complete an application, provide the official date of release and provide proof of citizenship.

3.2 Registration Requirements

A beneficiary who wishes to become eligible to receive entitled services shall register, together with any dependents under the age of 19, on a form provided by Medicare for this purpose, or be registered by a person acting on his or her behalf.

Upon approval of the application, the beneficiary and dependents are registered and a Medicare card with an expiry date is issued to the beneficiary and each dependent.

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary two or three months before the expiry date of the Medicare card or cards. A beneficiary who wishes to remain eligible to receive entitled services is required to confirm the information on the Notice of Expiry, to make any changes as appropriate and return the form to Medicare. Upon receiving the completed form, the file is updated and new card(s) are issued bearing a revised expiry date.

Currently in New Brunswick, only those individuals deemed eligible are registered.

All family members (the beneficiary, spouse and dependents under the age of 19) are required to register as a family unit. Residents who are co-habiting, but not legally married, are eligible to register as a family unit if they so request.

The number of residents registered as of March 31, 2004, was 738,030.

Residents may opt out of Medicare coverage if they choose. They are asked to provide written confirmation of their intention. This information is added to their files and benefits are terminated.

3.3 Other Categories of Individual

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible, provided that they are legally married to, or living in a common- law relationship with, an eligible New Brunswick resident and still possess a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document. As of March 31, 2004, 611 individuals were covered under immigration permits.

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period to obtain eligibility for Medicare coverage in New Brunswick. Coverage commences the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The legislation that defines portability of health insurance during temporary absences in Canada is the *Medical Services Payment Act*, Regulation 84-20, sections 3(4) and 3(5).

Students in full-time attendance at a university or other approved educational institution who leave New Brunswick to further their education in another province are granted coverage for a 12-month period that is renewable provided that they do the following:

☐ provide proof of enrolment;
☐ contact Medicare once every 12-month period to retain their eligibility;
☐ do not establish residence outside New Brunswick; and
☐ do not receive health coverage in another province.

Residents temporarily employed in another province or territory are granted coverage for up to 12 months provided that they do the following:

☐ do not establish residence in another province;
☐ do not receive coverage in another province; and
☐ intend to return to New Brunswick.

If absent longer than 12 months, residents should apply for coverage in the province or territory where they are employed and should be entitled to receive coverage there on the first day of the thirteenth month.

New Brunswick has formal agreements with all Canadian provinces and territories for reciprocal billing of insured hospital services. As well, New Brunswick has reciprocal agreements with all provinces except Quebec for the provision of insured physicians' services. Services provided by Quebec physicians to New Brunswick residents are paid at Quebec rates, if the service delivered is insured in New Brunswick. The majority of such claims are received directly from Quebec physicians. Any paid claims submitted by the patient are reimbursed to the patient according to New Brunswick Regulations.

During 2003-2004, New Brunswick paid the following amounts to other provinces and territories for insured health services:

Hospital in-patient	$26,085,533
Hospital out-patient	$5,200,814
Medical Services	$9,911,068

4.3 Coverage During Temporary Absences Outside Canada

The legislation that defines portability of health insurance during temporary absences outside Canada is the *Medical Services Payment Act*, Regulation 84-20, sections 3 (4) and 3 (5).

Students: Those in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another country, will be granted coverage for a 12-month period that is renewable, provided that they do the following:

- ☐ provide proof of enrolment;
- ☐ contact Medicare once every 12-month period to retain their eligibility;
- ☐ do not establish permanent residence outside New Brunswick; and
- ☐ do not receive health coverage elsewhere.

Temporary Workers: Residents temporarily employed outside the country are granted coverage for up to 12 months, regardless if it is known beforehand that they will be absent beyond the 12- month period, provided they do not establish residence outside Canada. Any absence over 182 days, whether it be for work purposes or vacation, would require the Director's approval. This approval can only be up to 12 months in duration and will only be granted once every three years. Families of workers temporarily employed outside Canada will continue to be covered, provided that they reside in New Brunswick.

Exception to Temporary Workers: Mobile workers are residents whose employment requires them to travel frequently outside the province. Certain guidelines must be met to receive Mobile Worker designation. These are as follows:

- ☐ applications must be submitted in writing;
- ☐ documentation is required as proof of Mobile Worker status (e.g., a letter from an employer or photocopy of an Immigration Permit);
- ☐ the worker's permanent residence must remain in New Brunswick; and
- ☐ the worker must return to New Brunswick during their off-time.
- ☐ the Mobile Worker designation is assigned for a maximum of two years, after which the resident must re-apply and re-submit documentation to confirm their status.

Contract Workers: Any New Brunswick resident accepting an out-of-country employment contract must supply the following information and documentation:

- ☐ letter of request from the New Brunswick resident with their signature, detailing their absence, including Medicare number, New Brunswick address, date of departure, destination and forwarding address, reason for absence and date of return; and
- ☐ copy of the contractual agreement between employee and employer that defines a start date and end date of employment.

Contract worker status is assigned for a maximum of two years. Any further requests for contract worker status must be forwarded to the Director of Medicare for approval on an individual basis.

New Brunswick Medicare covers out-of-country medical and hospital services for emergency out-patients and resulting in-patient services only. Medicare pays New Brunswick rates for physician services associated with the emergency interventions. The associated facility rates, paid in Canadian funds, are as follows: in-patient services $100 per day; out-patient services $50 per visit.

Medicare will cover out-of-country services that are not available in Canada on a prior approval basis only. Residents may opt to seek non-emergency out-of-country services; however, those who receive such services will assume responsibility for the total cost. In 2003-2004, New Brunswick paid the following amounts for services received outside Canada:

Hospital in-patient	$487,893
Hospital out-patient	$252,624
Medical Services	$422,544

4.4 Prior Approval Requirement

New Brunswick residents may be eligible for reimbursement if they receive elective medical services outside the country, provided they fulfill the following requirements:

- ☐ the required service, or equivalent or alternate service, must be unavailable in Canada;
- ☐ it must be rendered in a hospital listed in the current edition of the American Hospital Association Guide to the Health Care Field (guide to United States hospitals, health care systems, networks, alliances, health organizations, agencies and providers);
- ☐ the services must be rendered by a medical doctor; and
- ☐ the service must be an accepted method of treatment recognized by the medical community and be regarded as scientifically proven in Canada. Experimental procedures are not covered.

If the above requirements are met, it is mandatory to request prior approval from Medicare in order to receive coverage. A physician, patient or family member may request prior approval to receive these services outside the country, accompanied by supporting documentation from a Canadian specialist or specialists.

The following are considered exemptions under the out-of-country coverage policy:

- ☐ haemodialysis: patients will be required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the interprovincial rate of $220 per session; and
- ☐ allergy testing for environmental sensitivity: all tests sent outside the country will be paid at a maximum rate of $50 per day, an amount equivalent to an out-patient visit.

Prior approval is also required for referral of patients to psychiatric hospitals and addiction centres outside the province, because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received by Medicare from the Addiction Services or Mental Health branches of the Department of Health and Wellness.

5.0 Accessibilty

5.1 Access to Insured Health Services

New Brunswick charges no user fees for insured health services as defined by the Canada Health Act. Therefore, all residents of New Brunswick have equal access to these services.

5.2 Access to Insured Hospital Services

The New Brunswick Hospital Master Plan identifies the number of approved beds for each Regional Health Authority.

All facilities that provide insured services in accordance with the Canada Health Act have appropriate medical, surgical, rehabilitative and diagnostic equipment or systems corresponding to their designated levels of care. As of March 31, 2004, there were nine Computed Tomography (CT) scanners operating in New Brunswick – one in each of the eight RHAs, with a second unit operating in RHA 2. The Province also has two mobile Magnetic Resonance Imaging (MRI) units operating and three fixed-site MRI systems.

5.3 Access to Insured Physician and Surgical-Dental Services

A total of 694 general or family practitioners, 802 specialists, eight dentists and six orthodontists provided insured services in New Brunswick in 2003-2004.

In fiscal 2003-2004, the Department of Health and Wellness continued to work on its recruitment and retention strategy, aimed at attracting newly licensed family practitioners and specialists. This strategy, announced in 1999-2000, included a contingency fund to allow the Department to more effectively respond to potential recruitment opportunities, the provision of location grants of $25,000 for family practitioners and $40,000 for specialists willing to practice in under-serviced areas of the province and the purchase of five additional seats at the University of Sherbrooke's medical school, which began in September 2002. The recruitment and retention strategy also provides for increased government involvement in post-graduate training of family physicians, the maintenance of 300 weeks in summer rural preceptorship training for medical students and moving physician remuneration toward relative parity with other Atlantic provinces.

In February 2004, the Minister of Health and Wellness announced a two-year collaborative practice project to improve access to primary health care services. The pilot project will increase patient access by adding the services of nurses and nurse practitioners to physician's offices. A total of five office sites, three in Edmundston, one in Bathurst and one in Moncton have been selected. The project will continue until March 2006.

5.4 Physician Compensation

Fiscal 2003-2004 marked the second year of an agreement with fee-for-service physicians that provides for a 15 percent increase in fees over a three-year period (2002-2003 to 2004-2005). Discussions were held during the year with the New Brunswick Medical Society to implement the initiatives contained in that agreement.

There is no formal negotiation process for dental practitioners in New Brunswick.

Payments to physicians and dentists are governed under the *Medical Services Payment Act*, Regulations 84-20, 93-143 and 96-113.

The methods used to compensate physicians for providing insured health services in New Brunswick are fee-for-service, salary and sessional or alternate payment mechanisms that may also include a blended system.

5.5 Payments to Hospitals

The legislative authorities governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals and the *Hospital Services Act*, which governs the financing of hospitals. The *Regional Health Authorities Act*, which provides for the delivery and administration of health services in defined geographic areas within the province, came into force on April 1, 2002.

There were no changes during the 2003-2004 fiscal year affecting the hospital payment process.

The Department of Health and Wellness uses two components to distribute available funding to New Brunswick's eight RHAs.

The main component is a "Current Service Level" (CSL) base. This component addresses five main patient-care delivered services as follows:

- ☐ tertiary services (cardiac, dialysis, oncology);
- ☐ psychiatric services (psychiatric units and facilities);
- ☐ dedicated programs (e.g. addictions services);
- ☐ community-based services (Extra-Mural Program; health service centres); and
- ☐ general patient care.

Added to this are non-patient care support services (e.g. general administration, laundry, food services, energy).

The CSL approach establishes base budgets for the eight RHAs for the above-noted programs and services, with measures for population and service volumes. The base budgets are then adjusted annually for inflation and other factors such as centrally negotiated salary rates.

The population-based funding distribution formula, which was enhanced during fiscal 2000-2001, was still in use in fiscal year 2003-2004. This methodology attempts to predict the appropriate distribution of available funding for the RHAs based on demographic characteristics and current market share of patient volumes, with cases measured by "Resource Intensity Weights." Currently, this methodology is more suitable to in-patient volumes because of a lack of case grouping and weighting methodologies for out-patient volumes, especially tertiary out-patient services (e.g., oncology and haemodialysis).

The current budget process may extend over more than one fiscal year and includes several steps. By January of each year, RHAs are to provide the

Department with their utilization data and revenue projections for the following fiscal year, as well as their actual utilization data and revenue figures for the first nine months of the current fiscal year. This information, along with the audited financial statements from the previous two fiscal years, are used to evaluate the expected funding level for each RHA.

Budget amendments are provided during the year to allow for adjustments to applicable programs and services on either recurring or non-recurring bases. The "year-end settlement process" reconciles the total annual approved budget for each RHA to its audited financial statements and reconciles budgeted revenues and expenses to actual revenues and expenses.

6.0 Recognition Given to Federal Transfers

New Brunswick routinely recognizes the federal role regarding its contributions under the Canada Health and Social Transfer (CHST) in public documentation presented through legislative and administrative processes. These include the following:

☐ the Budget Papers presented by the Minister of Finance on March 30, 2004;
☐ the Public Accounts presented by the Minister of Finance on December 19, 2003; and
☐ the Main Estimates presented by the Minister of Finance on March 30, 2004.

New Brunswick does not produce promotional documentation on its insured medical and hospital benefits.

7.0 Extended Health Care Services

The New Brunswick Long Term Care program, a non-insured service, was transferred to the Department of Family and Community Services on April 1, 2000. Nursing home care, also a non-insured service, is offered through the Nursing Home Services program of the Department of Family and Community Services. Other adult residential care services and facilities are available through a variety of agencies and funding sources within the province.

Residential and Extended Care Services

Nursing homes are private, not-for-profit organizations, except for one facility that is owned by the Province. In order to be admitted to a nursing home, clients go through an evaluation process based on specific health condition criteria.

Adult Residential Facilities[1] are, for the most part, private and not-for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open and close residential facilities. Clients are admitted after going through the same evaluation process as used for nursing home admissions.

Public housing units are available for low-income elderly persons. Admission criteria are based on age and the applicant's financial situation. The Victorian Order of Nurses offers support services to some units.

Ambulatory Health Care

In New Brunswick, "ambulatory health care" includes services provided in hospital emergency rooms, day or night care in hospitals and in clinics if it is available in hospitals, health centres and Community Health Centres. This is considered an insured service under the provincial Hospital Services Plan.

Extra-Mural Program

The New Brunswick Extra-Mural Program, also known as the "hospital at home" program, is an active treatment program of acute, palliative and long-term health care and rehabilitation services provided in community settings (an individual's home, a nursing home or public school). Since

---

[1] Adult Residential Facilities include Special Care Homes and Community Residences.

1996, this Program has been delivered by New Brunswick's eight RHAs. Service providers include nurses, social workers, dieticians, respiratory therapists, physiotherapists, occupational therapists and speech language pathologists. These services, although not covered by the *Canada Health Act*, are considered an insured service under the provincial Hospital Services Plan.

Registered Persons	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#)	739,336	738,598	737,299	738,774	738,030

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#):					
a. acute care	31	31	31	31	31
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. other	0	0	0	0	0
e. total	32	32	32	32	32
3. Payments ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	722,600,000[1]	768,400,000[1]	839,100,000[1]	893,400,000[1]	961,200,000[1]
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
5. Number of insured hospital services provided (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
6. Payments ($):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	629	645	689	675	694
b. specialists	721	710	799	731	802
c. other	not available	not available	not available	not available	not available
d. total	1,350	1,355	1,488	1,406	1,496
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	3,721,782	3,668,781	3,611,747	3,731,076	3,580,740
b. specialists	2,612,744	2,590,346	2,552,018	2,669,294	2,678,372
c. other	not available	not available	not available	not available	not available
d. total	6,334,526	6,259,127	6,163,765	6,400,370	6,259,112
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	77,958,130	78,139,070	85,584,720	100,812,443	100,358,397
b. specialists	111,554,173	111,224,207	120,128,708	137,047,629	140,873,627
c. other	not available	not available	not available	not available	not available
d. total	189,512,303	189,363,277	205,713,428	237,860,072	241,232,024
12. Average payment per fee for service service ($):					
a. general practitioners	20.95	21.30	23.70	27.02	28.03
b. specialists	42.70	42.94	47.07	51.34	52.60
c. other	not available	not available	not available	not available	not available
d. all services	29.92	30.25	33.37	37.16	38.54
13. Number of services provided through all payment methods (#): [2]					
a. medical	739,911	728,947	705,799	749,181	699,298
b. surgical	852,725	839,980	826,342	887,993	913,827
Radiology services- auto FFS			23,289	186,140	177,185
c. diagnostic	1,020,108	1,021,419	1,019,877 [3]	1,032,120 [3]	1,065,247 [3]
d. other	3,721,782	3,668,781	3,611,747 [4]	3,731,076 [4]	3,580,740 [4]
e. total	6,334,526	6,259,127	6,163,765	6,400,370	6,259,112
14. Total payments to physicians paid through all payment methods ($): [2]					
a. medical	41,795,791	41,068,744	43,830,630	50,457,210	51,311,084
b. surgical	48,732,272	47,840,045	52,103,502	60,579,805	61,017,689
Radiology payments- auto FFS			516,903	3,928,001	4,011,187
c. diagnostic	21,026,109	22,315,418	24,194,576 [3]	26,010,614 [3]	28,544,854 [3]
d. other	77,958,130	78,139,070	85,584,720 [4]	100,812,443 [4]	100,358,397 [4]
e. total	189,512,302	189,363,277	205,713,428	237,860,072	241,232,024
15. Average payment per service, all payment methods ($): [2]					
a. medical	56.49	56.34	62.10	67.35	73.38
b. surgical	57.15	56.95	63.05	68.22	66.77
c. diagnostic	20.61	21.85	22.20	21.10	22.64
d. other	20.95	21.30	23.70 [4]	27.02 [4]	28.03 [4]
e. all services	29.92	30.25	33.37	37.16	38.54

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	3,900 pts / 25,655 days	4,130 pts / 26,572 days	3,796 pts / 23,342 days	4,168 pts / 23,949 days	3,338 pts / 27,933 days
17. Total number of claims, out-patient (#).	32,796	35,834	36,687	40,145	38,096
18. Total payments, in-patient ($).	22,473,974	21,561,907	19,110,500	23,477,103	26,085,533
19. Total payments, out-patient ($).	4,235,429	4,702,219	5,261,500	5,387,946	5,200,814
20. Average payment, in-patient ($).	876.01	811.45	818.72	980.30	933.86
21. Average payment, out-patient ($).	129.14	131.22	143.42	134.21	136.52
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	137,950	141,014	161,415	178,569	200,706
23. Total payments ($).	6,050,729	6,280,048	7,721,995	9,303,055	9,911,068
24. Average payment per service ($).	40.50	43.86	47.84	52.10	49.38

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	212 pts / 1,691 days	166 pts / 1,096 days	148 pts / 1,447 days	180 pts / 843 days	166 pts / 1,367 days
26. Total number of claims, out-patient (#).	524	639	1,003	1,000	1,013
27. Total payments, in-patient ($).	487,760	458,759	440,088	420,659	487,893
28. Total payments, out-patient ($).	105,783	180,712	133,360	244,217	252,624
29. Average payment, in-patient ($).	288.44	418.58	304.14	290.71	356.91
30. Average payment, out-patient ($).	201.88	282.80	132.96	244.22	249.38
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	4,554	4,202	4,360	5,018	5,419
32. Total payments ($).	356,128	362,994	482,915	395,061	422,544
33. Average payment per service ($).	58.17	78.20	110.76	78.73	77.97

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	12	16	12	16	14
35. Number of services provided (#).	751	1,004	1,010	1,283	1,232
36. Total payments ($).	136,491	189,777	186,944	208,946	188,634
37. Average payment per service ($).	181.75	189.02	185.09	162.86	153.11

Endnotes

1. Gross hospital facility expenditures as shown in the New Brunswick Annual Reports.
2. Fee-for-service payments only.
3. Actual Radiology payments from Fee-for-Service Manual Payments.
4. Includes General Practitioners.

Quebec

1.0 Public Administration

1.1 Health Insurance Plan and Public Authority

The hospital insurance plan, the Regime d'assurance-hospitalisation du Quebec [Quebec Health Insurance Plan], is administered by the Ministere de la Sante et des Services sociaux [Quebec Department of Health and Social Services] (MSSS).

The health insurance plan, the Regime d'assurance-maladie du Quebec, is administered by the Regie de l'assurance maladie du Quebec [Quebec Health Insurance Board] (RAMQ), a public body established by the provincial government and responsible to the Minister of Health and Social Services.

1.2 Reporting Relationship

The Public Administration Act (R.S.Q., chapter A-6.01) sets out the government criteria for preparing reports on the planning and performance of public authorities, including the MSSS and the RAMQ.

1.3 Audit of Accounts

Both plans (the Quebec Hospital Insurance Plan and the Quebec Health Insurance Plan) are operated on a non-profit basis. All books and accounts are audited by the Auditor General of Quebec.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured in-patient services include: standard ward accommodation and meals; necessary nursing services; routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anaesthetic facilities; medications, prosthetic and orthotic devices that can be integrated with the human body; biologicals and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital centre staff.

Out-patient services include: clinical services for psychiatric care; electroshock, insulin and behaviour therapies; emergency care; minor surgery (day surgery); radiotherapy; diagnostic services; physiotherapy; occupational therapy; inhalation therapy, audiology, speech therapy and orthoptic services; and other services or examinations required under Quebec legislation.

Other services covered by insurance are: mechanical, hormonal or chemical contraception services; surgical sterilization services (including tubal ligation or vasectomy); reanastomosis of the fallopian tubes or vas deferens; and ablation of a tooth or root when the health status of the person makes hospital services necessary.

The MSSS administers an ambulance transportation program free of charge to persons aged 65 or older.

In addition to the basic insured health services, the RAMQ also covers the following, with some limitations for certain residents of Quebec as defined by the Health Insurance Act and for employment assistance recipients: optometric services; dental care for children and employment assistance recipients, and acrylic dental prostheses for employment assistance recipients; prostheses, orthopaedic appliances, locomotion and postural aids, and other equipment that helps with a physical disability; external breast prostheses; ocular prostheses; hearing aids, assistive listening devices and visual aids for people with a visual or auditory disability; and permanent ostomy appliances.

Since January 1, 1997, in terms of drug insurance, the RAMQ covers, over and above its regular clientele (employment assistance recipients and persons 65 years of age or older), individuals who do not have access to a private drug insurance plan. The new drug insurance plan covers 3.2 million insured persons.

2.2 Insured Physician Services

The services insured under this plan include medical and surgical services that are provided by physicians and are required from a medical standpoint.

2.3 Insured Surgical-Dental Services

The services insured under this plan include oral surgery performed in a hospital centre or university institution determined by regulation, by dental surgeons and specialists in oral and maxillo-facial surgery.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include: plastic surgery; in-vitro fertilization; a private or semi-private room at the patient's request; televisions; telephones; drugs and biologicals ordered after discharge from hospital; and services for which the patient is covered under the Act Respecting Industrial Accidents and Occupational Diseases or other federal or provincial legislation.

The following services are not considered insured:

☐ any examination or service not related to a process of cure or prevention of illness;
☐ psychoanalysis of any kind, unless such service is rendered in an institution authorized for this purpose by the Minister of Health and Social Services;
☐ any service rendered solely for aesthetic purposes;
☐ any refractive surgery, except in cases where there is documented failure for astigmatism of more than 3.00 diopters or for anisometropia of more than 5.00 diopters, measured at the cornea, when corrective lenses or corneal lenses are worn;
☐ any consultation by telecommunication or by correspondence;
☐ any service rendered by a professional to his or her spouse or children;
☐ any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than the one who has received an insured service, except in certain cases;
☐ any visit made for the sole purpose of obtaining the renewal of a prescription;
☐ any examinations, vaccinations, immunizations or injections, where the service is provided to a group or for certain purposes;
☐ any service rendered by a professional on the basis of an agreement or a contract with an employer, an association or an organization;
☐ any adjustment of eyeglasses or contact lenses;
☐ any surgical ablation of a tooth or tooth fragment performed by a physician, except where the service is provided in a hospital centre in certain cases;
☐ all acupuncture procedures;
☐ injection of sclerosing substances and the examination done at that time;
☐ thermography or mammography used for screening purposes, unless this service is delivered on a doctor's order in a place designated by the Minister, in either case, to a recipient who is age 35 or older, on condition that such an examination has not been performed on the recipient in the previous year;
☐ tomodensitometry, magnetic resonance imaging and use of radionuclides in vivo in a human, unless these services are rendered in a hospital centre;
☐ ultrasonography, unless this service is rendered in a hospital centre or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose;

☐ any radiological or anaesthetic service provided by a physician if required with a view to providing an uninsured service, except for a dental service provided in a hospital centre, or, in the case of a radiology service, if required by a person other than a physician or dentist;

☐ any sex-reassignment surgical service, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose; and

☐ any services that are not associated with a pathology and that are rendered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim card, for colour blindness or a refraction problem, in order to provide or renew a prescription for eyeglasses or contact lenses.

3.0 Universality

3.1 Eligibility

Registration with the hospital insurance plan is not required. Registration with the *Régie de l'assurance maladie du Québec* (RAMQ) or proof of residence is sufficient to establish eligibility. All persons who reside or stay in Quebec must be registered with the RAMQ to be eligible under the health insurance plan.

3.2 Requirements Concerning Registration with the Plan

Registration with the hospital insurance plan is not required. Registration with the RAMQ or proof of residence is sufficient to establish eligibility.

3.3 Other Categories of Persons

Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police and inmates of federal penitentiaries are not covered by the plan. No premium payment exists.

Certain categories of resident, for example permanent residents under the *Immigration Act* and persons returning to Canada to live, become eligible under the plan following a waiting period of up to three months. Persons receiving last resort financial assistance are eligible when they register. Members of the Canadian Forces and Royal Canadian Mounted Police who have not acquired the status of Quebec resident become eligible the day they arrive. Inmates of federal penitentiaries become eligible the day they are released. Immediate coverage is provided to certain seasonal workers, repatriated Canadians, persons from outside Canada who are living in Quebec under an official bursary or internship program of the *Ministère de l'Éducation* [Quebec Department of Education], and refugees. Persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for a period of more than six months become eligible for the plan following a waiting period.

4.0 Portability

4.1 Minimum Period of Residence

Persons settling in Quebec after moving from another province of Canada are entitled to coverage under the Quebec Health Insurance Plan when they cease to be entitled to benefits from their province of origin, provided they register with the RAMQ.

4.2 Coverage During Temporary Absences Outside Quebec (in Canada)

If living outside Quebec in another province or territory for 183 days or more, students and full-time unpaid trainees may retain their status as residents of Quebec; in the first case for four consecutive calendar years at most, and in the second case for two consecutive calendar years at most.

This is also the case for persons living in another province or territory for the purpose of holding temporary employment or working on contract there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons directly employed or working on contract outside Quebec in another province or territory, for a company or corporate body having its headquarters or a place of business in Quebec, or employed by the federal government and posted outside Quebec also retain their status as residents of the province, provided their families remain in Quebec or they retain a dwelling there.

Status as a resident of the province is also maintained by persons who remain outside the province for 183 days or more, but less than 12 months within a calendar year, provided such absence occurs only once every seven years and provided they notify the RAMQ of their absence.

The costs of medical services received in another province or a territory of Canada are reimbursed at the amount actually paid or the rate that would have been paid by the RAMQ for such services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for emergency care and when the specialized services provided are not offered in the Outaouais region. This agreement became effective on November 1, 1989. A similar agreement was signed in December 1991 between the *Centre de santé Témiscamingue* [Témiscamingue Health Centre] and North Bay.

Costs of hospital services received in another province or territory of Canada are paid according to the terms and conditions of the interprovincial agreement on reciprocal billing in the area of hospital insurance agreed on by the provinces and territories of Canada. In-patient costs are paid at standard ward rates approved by the host province or territory. Out-patient costs or the costs of expensive procedures are paid at approved interprovincial/territorial rates. However, since November 1, 1995, Quebec reimburses the Ottawa hospital centre a maximum of $450 per day of hospitalization when an Outaouais resident is hospitalized in a hospital centre in Ottawa for non-urgent care or when services are not available in the Outaouais.

Insured persons who leave Quebec to settle in another province or a territory of Canada are covered for up to three months after leaving the province.

4.3 Coverage During Temporary Absences Outside Quebec – Outside Canada

Students, unpaid trainees, Quebec government officials posted abroad and employees of non-profit organizations working under programs of international aid or co-operation recognized by the MSSS must contact the RAMQ to determine their eligibility. If the RAMQ recognizes them as having special status, they receive full reimbursement of their hospital costs in case of emergency or sudden illness, and 75 percent reimbursement in other cases.

Persons directly employed or working on contract outside Canada, for a company or corporate body having its headquarters or place of business in Quebec, or employed by the federal government and posted outside Quebec, also retain their status as residents of the province, provided their families remain in Quebec or they retain a dwelling there.

As of September 1, 1996, hospital services provided outside Canada in case of emergency or sudden illness are reimbursed by the RAMQ, usually in Canadian funds, to a maximum of C$100 per day if the patient was hospitalized (including in the case of day surgery) or to a maximum of C$50 per day for out-patient services.

However, haemodialysis treatments are covered to a maximum of C$220 per treatment. In such cases, the RAMQ reimburses the costs for the associated professional services. The services must be dispensed in a hospital or hospital centre recognized and accredited by the competent authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the RAMQ to a health professional recognized in Quebec, up to the amount of the expenses actually incurred. The costs of all services insured in the province are reimbursed at the Quebec rate, usually in Canadian funds, when they are incurred abroad.

Coverage is discontinued on the day of departure for insured residents who move permanently to another country.

4.4 Prior Approval Requirement

Insured persons requiring medical services in a hospital abroad, if those services are unavailable in Quebec or elsewhere in Canada, are reimbursed 100 percent with prior consent for medical and hospital services that meet certain conditions. Consent is not given by the plan's officials if the medical service in question is available in Quebec or elsewhere in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Everyone has the right to receive adequate health care services without any kind of discrimination. There is no extra-billing by Quebec physicians.

5.2 Access to Insured Hospital Services

On March 31, 2004, Quebec had 125 institutions operating as hospital centres for a clientele suffering from acute illness, with 21,667 beds for persons requiring care for acute physical or psychiatric ailments allotted to these institutions. From April 1, 2002, to March 31, 2003, Quebec hospital institutions had nearly 685,600 admissions for short stays and close to 287,100 registrations for day surgeries. These hospitalizations and registrations accounted for more than 5,000,000 patient days.

Restructuring of the health network: In November 2003, Quebec announced the implementation of local services networks covering all of Quebec. At the heart of each local network is a new local authority, the "health and social services centre". These centres resulted from merging the public institutions whose mission it was to provide CLSC (local community service centre) services, residential and long-term care, and, in most cases, neighbourhood hospital services. The health and social services centres also provide the people in their territory with access to other medical services, general and specialized hospital services and social services. To do so, they will have to enter into service agreements with other health sector organizations. The linking of services within a territory forms the local services network. Thus, the integrated local health and social services networks lead all the stakeholders in a given territory to make themselves collectively responsible for the health and well-being of the people in that territory.

Management of waiting lists: In October 2003, the MSSS began publishing its waiting lists on its Web site for each hospital. It now provides physicians and institutions with a computerized service access management system. This tool is based on the concept of "access within a clinically acceptable period," as defined by committees of medical experts in certain fields and, within waiting times for access, as defined by committees of physicians. Once applied uniformly throughout the province of Quebec, these guidelines will ensure that all patients, regardless of their place of origin, will be treated according to the same criteria. Once deployed, this system will supply the data for the new waiting lists site and will enable the patients and professionals concerned to obtain appropriate, reliable and up-to-date information on activities of hospital centres and waiting periods for various services.

5.3 Access to Insured Physician and Surgical-Dental Services

Primary care: In 2003-2004, family medicine groups (FMGs) were established. They work in close collaboration with the local community service centres (CLSCs) and other network resources to provide services such as health assessment, case management and follow-up, diagnosis, treatment of acute and chronic problems, and disease prevention. Their services are available 24 hours a day, seven days a week.

5.4 Compensation/Remuneration of Physicians

Physicians are paid according to the negotiated fee schedule. Physicians who have withdrawn from the health insurance plan are paid directly by the patient according to the fee schedule after the patient has collected from the RAMQ. Non-participating physicians are paid directly by the patients according to the amount charged.

Provision is made in law for reasonable compensation for all insured health services rendered by health professionals. The Minister may enter into an agreement with the organizations representing any class of health professional. This agreement may prescribe a different rate of compensation for medical services in a territory where the number of professionals is considered insufficient. The Minister may also provide for a different rate of compensation for general practitioners and medical specialists during the first years of practice, depending on the territory or the activity involved. These provisions are preceded by consultation with the organizations representing the professional groups.

While most physicians practise within the provincial plan, Quebec allows two other options: that where professionals withdraw from the plan and practise outside the plan, but agree to remuneration according to the provincial fee schedule; and that where non-participating professionals practise outside the plan and neither they nor their patients receive reimbursement from the RAMQ.

In 2003-2004, the RAMQ paid $3,064.2 million to doctors in the province, while the amount for medical services outside the province reached an estimated $10.0 million.

5.5 Payments to Hospital Centres

Hospital centres are funded by the Minister of Health and Social Services through payments in respect of the cost of insured services provided.

The payments made in 2002-2003 to institutions operating as hospital centres for insured health services provided to persons living in Quebec were more than $6.4 billion; payments to hospital centres outside Quebec were approximately $82.8 million.

7.0 Extended Health Care Services

Intermediate care, adult residential care and home care services are available, with admission coordinated on a regional level and based on a single assessment tool. The local community service centres (CLSCs) receive individuals, evaluate their care requirements and either arrange for the provision of such services as day centre programs or home care, or refer them to the appropriate agencies.

The MSSS offers some home care services, including nursing care and assistance, homemaker services and medical surveillance.

Residential facilities and long-term care units in acute-care hospitals focus on maintaining their clients' autonomy and functional abilities by providing them with a variety of programs and services, including health care services.

Ontario

Introduction

Ontario has one of the largest and most complex publicly funded health care systems in the world. Administered by the province's Ministry of Health and Long-Term Care (MOHLTC), Ontario's health care system was supported by over $29 billion in spending for 2003-2004. MOHLTC is responsible for providing services to the Ontario public through such programs as:

- ☐ health insurance;
- ☐ drug benefits;
- ☐ assistive devices;
- ☐ mental health services;
- ☐ home care;
- ☐ community support services;
- ☐ public health; and
- ☐ health promotion and disease prevention.

MOHLTC also regulates and funds hospitals and long-term care homes (nursing homes and homes for the aged), operates psychiatric hospitals and medical laboratories, and funds and regulates or directly operates emergency health services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is administered on a non-profit basis by MOHLTC.

OHIP is established under the *Health Insurance Act* (HIA), Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services provided in hospitals and health facilities and by physicians and other health care practitioners.

There were no amendments to the *Health Insurance Act* in 2003-2004.

1.2 Reporting Relationship

OHIP is administered by MOHLTC.

1.3 Audit of Accounts

MOHLTC is audited annually by the Provincial Auditor. The Provincial Auditor's 2004 Annual Report was released on November 30, 2004.

MOHLTC's accounts and transactions are published annually in the Public Accounts of Ontario. The 2003-2004 Public Accounts of Ontario was released on September 27, 2004.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured in-patient and out-patient hospital services in Ontario are prescribed under the *Health Insurance Act* and Regulation 552 under that Act.

Insured in-patient hospital services include medically required:

- ☐ use of operating rooms, obstetrical delivery rooms and anaesthetic facilities.
- ☐ necessary nursing services;
- ☐ laboratory, radiological and other diagnostic procedures;
- ☐ drugs, biologicals and related preparations; and
- ☐ accommodation and meals at the standard ward level;

Insured out-patient services include medically required:

- ☐ laboratory, radiological and other diagnostic procedures;

☐ use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
☐ use of diet counseling services;
☐ use of the operating room, anesthetic facilities, surgical supplies, necessary nursing service, and supplying of drugs, biologicals and related preparations (subject to some exceptions)
☐ provision of equipment, supplies and medication to haemophiliac patients for use at home;
☐ cyclosporine to transplant patients;
☐ zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection;
☐ biosynthetic human growth hormone to patients with endogenous growth hormone deficiency;
☐ drugs for treatment of cystic fibrosis and thalassemia;
☐ erythropoeitins to patients with anaemia of end-stage renal disease;
☐ alglucerase to patients with Gaucher disease;
☐ clozapine to patients with treatment-resistant schizophrenia; and
☐ the administration of a rabies vaccine.

In 2003-2004 there were 152 public hospital corporations (excluding specialty hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and long-term care homes) staffed and in operation in Ontario. This includes 135 acute care hospital corporations, 13 chronic care hospitals and four general and special rehabilitation units.

Hospitals are categorized by major activity, though they provide a mix of services. For example, many acute care hospitals offer chronic care services, just as many chronic care facilities also offer rehabilitation.

When insured physician services are provided in licensed facilities outside of hospitals and where the total cost paid for these insured services is not included in the physician fees paid under the *Health Insurance Act*, MOHLTC provides funding through the payment of facility fees under the *Independent Health Facilities Act* (IHFA). Facility fees cover the cost of the premises, equipment, supplies and personnel utilized to render an insured service. Under the IHFA, patient charges for facility fees are prohibited.

Facility fees are charged to the government only by facilities that are licensed under the IHFA. Examples of facilities that are licensed under the IHFA include surgical/treatment facilities (e.g. those providing abortions, cataract surgery, dialysis and non-cosmetic plastic surgery) and diagnostic facilities (e.g. those providing x-ray, ultrasound, nuclear medicine, sleep studies and pulmonary function studies). New facilities are ordinarily established through a request for proposals process based on an assessment of need for the service.

2.2 Insured Physician Services

Insured physician services are prescribed under the *Health Insurance Act* and regulations under that Act.

Under subsection 37.1(1) of Regulation 552 of the *Health Insurance Act*, a service provided by a physician in Ontario is an insured service if it is medically necessary, contained in the Schedule of Benefits and rendered in such circumstances or under such conditions as outlined in the Schedule of Benefits. Physicians provide primary health care services as well as medical, surgical and diagnostic services. Services are provided in a variety of settings including private physician offices, health service organizations, community health centres, hospitals, mental health facilities, independent health facilities, walk-in clinics and long-term care homes.

In general terms, insured physician services include:

☐ diagnosis and treatment of medical disabilities and conditions;
☐ medical examinations and tests;
☐ surgical procedures;
☐ maternity care;
☐ anaesthesia;
☐ radiology and laboratory services in approved facilities; and
☐ immunizations, injections and tests.

The Schedule of Benefits is regularly reviewed and revised to reflect current medical practice and new technologies. New services may be added, existing services revised or obsolete services removed through regulatory amendment. This process involves consultation with the Ontario Medical Association.

During 2003-04 physicians could submit claims for all insured services rendered to insured persons directly to OHIP, in accordance with section 15 of the *Health Insurance Act*, or they could bill the insured person, as specified in section 15 of the Act (see also Part II of the *Commitment to the Future of Medicare Act*). Physicians who do not bill OHIP directly are commonly referred to as having "opted-out". When a physician has opted-out, the physician bills the patient (not exceeding the amount payable for the service under the Schedule of Benefits), and the patient is then entitled to reimbursement by OHIP. However, opting-out is no longer generally allowed following proclamation of the *Commitment to the Future of Medicare Act* on September 23, 2004. Physicians who did not bill OHIP directly prior to May 13, 2004 may continue to do so if they notify the ministry of their intent to do so by December 23, 2004.

Physicians must be registered to practice medicine in Ontario by the College of Physicians and Surgeons of Ontario.

There were approximately 21,000 physicians who submitted claims to OHIP in 2003-2004.

2.3 Insured Surgical-Dental Services

Insured surgical-dental services are prescribed under section 16 and the Dental Schedule of Benefits under Regulation 552 of the *Health Insurance Act*. These services, for which hospitalization is medically necessary, include the following:

☐ repair of traumatic injuries;
☐ surgical incisions;
☐ excision of tumours and cysts;
☐ treatment of fractures;
☐ homeografts;
☐ implants;
☐ plastic reconstructions; and
☐ all other specified dental procedures.

Approximately 320 dentists and dental/oral surgeons provided insured surgical-dental services in Ontario in 2003-2004.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services prescribed by and rendered in accordance with the *Health Insurance Act* and regulations under that Act are insured. Section 24 of Regulation 552 details those services that are specifically prescribed as uninsured. Uninsured hospital services include:

☐ additional charges for preferred accommodation unless prescribed by a physician, oral-maxillofacial surgeon, or midwife;
☐ telephones and televisions;
☐ charges for private-duty nursing;
☐ cosmetic surgery under most circumstances;
☐ provision of medications for patients to take home from hospital, with certain exceptions; and
☐ in-province hospital visits solely for the administration of drugs, subject to certain exceptions.

Uninsured physician services include:

☐ services that are not medically necessary;
☐ toll charges for long-distance telephone calls;
☐ preparing or providing a drug, antigen, antiserum or other substance unless the drug, antigen or antiserum is used to facilitate a procedure;
☐ advice given by telephone at the request of the insured person or the person's representative;
☐ an interview or case conference (in limited circumstances);
☐ preparation and transfer of records at the insured person's request;
☐ a service that is received wholly or partly for the production or completion of a document or the transmission of information to a "third party" in specified circumstances;

☐ the production or completion of a document or the transmission of information to any person other than the insured person in specified circumstances;

☐ provision of a prescription when no concomitant insured service is rendered;

☐ cosmetic surgery;

☐ acupuncture procedures;

☐ psychological testing; and

☐ research and survey programs.

Effective September 23, 2004 Part II of the *Commitment to the Future of Medicare Act* (CFMA) prohibits physicians from charging patients or accepting payments from patients for more than the amount payable by OHIP for the insured service. The *Commitment to the Future of Medicare Act* also prohibits payment or accepting payment to obtain preferred access to an insured service. Prior to the CFMA, the *Health Insurance Act* and the *Health Care Accessibility Act* prohibited physicians from charging patients or accepting payments from patients for more than the amount payable by OHIP for the insured service.

3.0 Universality

3.1 Eligibility

With certain exceptions in which the waiting period is waived, residents of Ontario, as defined in Regulation 552 of the *Health Insurance Act*, are eligible for Ontario health coverage subject to a three-month waiting period. To be considered a resident of Ontario for the purpose of obtaining Ontario health coverage, a person must:

☐ hold Canadian citizenship or an immigration status as prescribed in Regulation 552;

☐ make his or her permanent and principal home in Ontario;

☐ be physically present in Ontario for at least 153 days in any 12-month period; and

☐ be physically present in Ontario for 153 of the first 183 days following the date that the person establishes residency in Ontario (a person cannot be away from the province for more than 30 days in the first 6 months of residency).

With certain exceptions as set out in Regulation 552, most new and returning residents are subject to a three-month waiting period. MOHLTC will determine whether or not an individual is subject to the three-month waiting period at the time of their application for health coverage. Those who are exempt from the three-month waiting period include Convention Refugees and Protected Persons, newborn babies born in Ontario and insured residents from another province/territory who move to Ontario and immediately become residents of approved charitable homes, homes for the aged or nursing homes in Ontario.

Individuals who are not eligible for Ontario health coverage include those who hold an immigration status that is not set out in Regulation 552 such as refugee claimants (who are not Convention Refugees) and visitors to the province. Other individuals such as federal penitentiary inmates, Canadian Forces and Royal Canadian Mounted Police personnel are also not provided with Ontario health coverage if they are provided with health coverage under a federal health care plan.

Persons who were previously ineligible for Ontario health coverage but whose status has changed (e.g. change in immigration status or release from a federal penitentiary) may, upon application, be eligible subject to the requirements of Regulation 552.

3.2 Registration Requirements

Every resident of Ontario who seeks Ontario health coverage is required to register with the MOHLTC.

A health card is issued to eligible residents upon application to the General Manager of OHIP, pursuant to sections 2 and 3 of Regulation 552. Eligible persons should apply for coverage upon establishing their permanent and principal home in the province. Registration is done through local OHIP offices. Applicants for Ontario health coverage must complete and sign a Registration for Ontario Health Coverage form and provide the ministry with original documents to prove their Canadian citizenship or eligible immigration status, their residency in Ontario and their identity. Eligible applicants over the age of 15.5 are also generally required to have their photographs and signatures captured for their photo health cards.

Each photo health card has a card renewal/expiry date in the bottom right-hand corner of the card. MOHLTC mails renewal notices to registrants approximately six weeks before the card's renewal date.

MOHLTC is the sole payer for insured health services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for any insured service that is covered by OHIP.

Approximately 12.2 million Ontario residents were registered with OHIP and held valid and active Health Cards as of as of March 31, 2004.

3.3 Eligible Residents of Ontario

MOHLTC provides health coverage to other residents of Ontario other than Canadian citizens and Permanent Residents/Landed Immigrants . These residents are required to provide acceptable documentation to support their eligible immigration status, their residency in Ontario and their identity in the same manner as Canadian citizen or Permanent Resident/Landed Immigrant applicants.

The individuals listed below who are ordinarily resident in Ontario will be eligible for Ontario health coverage in accordance with Regulation 552 and prevailing ministry policy. Clients applying for coverage under any of these categories should contact their local OHIP office for further details.

Applicants for Permanent Residence/ Applicants for Landing – These are persons who are being processed for Permanent Resident/Landed Immigrant status by Citizenship and Immigration Canada (CIC) and have met CIC's medical requirements.

Convention Refugees and Protected Persons – The federal Immigration and Refugee Board designates a person as a Convention Refugee when that person has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group, or political opinion. CIC may also determine that a person is a Protected Person under the terms of the Immigration and Refugee Protection Act if returning to their country of origin would pose a substantial risk to the person's life or to torture or cruel and unusual punishment.

Holders of Temporary Resident Permits/Minister's Permits – Temporary Resident Permits/Minister's Permits are documents that indicate that the holder has not immediately met CIC's requirements to remain permanently in Canada. Holders of a Temporary Resident Permit/Minister's Permit with a case type of 80 (adoption only), 86, 87, 88, or 89 are typically being processed towards Permanent Resident status and are eligible for Ontario health coverage for the duration of their permit if they will be residing in Ontario. Holders of a Temporary Resident Permit/Minister's Permit with a case type of 80, 81, 84, 85, 90, 91, 92, 93, 94, 95 and 96 are typically refused applicants for Permanent Resident status on medical or criminal grounds or are merely visiting for a short period of time and are not eligible for Ontario health coverage.

Clergy, Foreign Workers and their Accompanying Family Members – An eligible foreign clergy is a person who is sponsored by a religious organization or denomination and has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer situated in Ontario and has been issued a Work Permit/Employment Authorization by CIC that names the Canadian employer, states the person's prospective occupation, and has been issued for a period of at least six months.

Spouses, same sex partners and/or dependant children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker are also eligible for Ontario health coverage if the member of the clergy or the foreign worker is to be employed in Ontario for at least three consecutive years and if the family member will be ordinarily a resident of Ontario.

Live-in Caregivers – Live-in Caregivers are persons who have been issued a Work Permit/Employment Authorization under the Live-in Caregivers in Canada Program (LCP) or the Foreign Domestic Movement (FDM) administered by CIC. An eligible Live-in Caregiver is a person who holds a valid LCP or FDM Work Permit/Employment Authorization issued by CIC and who is ordinarily a resident of Ontario. The Work Permit/Employment Authorization for LCP or FDM workers does not have to list the three specific employment conditions required by all other foreign workers.

Migrant Farm Workers – Migrant farm workers are persons who have been issued a Work Permit/Employment Authorization under the Caribbean, Commonwealth and Mexican Seasonal Agriculture Workers Program administered by CIC. Due to the special nature of their employment, migrant farm workers are not required to present residency documents generally required to establish eligibility for OHIP coverage. Members of this group are also exempt from the three-month waiting period.

4.0 Portability

4.1 Minimum Waiting Period

In accordance with subsection 3(3) of Regulation 552 under the *Health Insurance Act* and Ministry policy, individuals who move to Ontario are entitled to OHIP coverage beginning three months after establishing residency in the province, unless listed as an exception in section 3(4).

4.2 Coverage During Temporary Absences in Canada

Out-of-province services are covered under sections 28, 30(1) and 32 of Regulation 552 of the *Health Insurance Act*.

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability. In accordance with that agreement, insured residents who are outside Ontario temporarily can use their Ontario Health Cards to obtain insured health services.

An insured person who leaves Ontario temporarily to travel within Canada without establishing residency in another province or territory will continue to be covered by OHIP for a period of up to 12 months.

An insured person who seeks or accepts employment in another province or territory will continue to be covered for a period of up to 12 months. If the individual plans to remain outside Ontario beyond the 12-month maximum, he or she should apply for coverage in the province or territory where that person has been working or seeking work.

Insured students who are temporarily absent from Ontario, but remain within Canada, are eligible for continuous health coverage for the duration of their full-time studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, a student should provide MOHLTC with letters from their educational institution confirming registration as a full-time student. Family members of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying students for the duration of their studies.

Ontario participates in reciprocal agreements with all other provinces and territories for insured hospital in- and out-patient services. Payment is at the in-patient rate of the plan in the province or territory where hospitalization occurs. Ontario pays the standard out-patient charges authorized by the Coordinating Committee on Reciprocal Billing.

In addition, section 28 of Regulation 552 of the *Health Insurance Act* sets out payment for insured hospital services outside Ontario but within Canada that are not billed through the reciprocal arrangements.

Ontario also participates in reciprocal billing arrangements with all other provinces and territories, except Quebec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services. Ontario residents who may be required to pay for doctors' services received in Quebec can submit their receipts to the Ministry of Health and Long-Term Care for repayment.

4.3 Coverage During Extended Absences Outside Canada

Health coverage for insured Ontario residents during extended absences outside Canada is governed by sections 28.1 through 29 (inclusive) and section 31 of Regulation 552 of the *Health Insurance Act*.

In accordance with sections 1.1(3), 1.1 (4), 1.1(5) and 1.1(6) of Regulation 552 of the *Health Insurance Act*, MOHLTC may provide insured Ontario residents with continuous Ontario health coverage during absences outside Canada of longer than 212 days (seven months) in a 12-month period.

Residents are required to apply to the MOHLTC for this coverage prior to their departure and must provide a document explaining the reason for their absence outside Canada. In accordance with the regulations and ministry policy, most applicants must also have been present in Ontario for at least 153 days in each of the two consecutive 12-month periods prior to their expected date of departure.

The length of time that the MOHLTC will provide a person with continuous Ontario health coverage during an extended absence outside Canada varies depending on the reason for the absence. Please refer to the information below for further details:

Reason	**OHIP Coverage**
Study	Duration of a full-time academic program (unlimited)
Work	Five-year terms
Missionary Work	Duration of missionary activities (unlimited)
Vacation/Other	Up to two years in a lifetime

Family members may also qualify for continuous Ontario health coverage while accompanying the primary applicant on an extended absence outside Canada and should contact their local OHIP office for details.

Out-of-country services are covered under section 28.1 to 28.6 inclusive, and sections 29 and 31 of Regulation 552 of the *Health Insurance Act*.

Effective September 1, 1995, out-of-country emergency hospital costs are reimbursed at Ontario fixed per diem rates of:

- ☐ a maximum $400 Canadian for in-patient services;
- ☐ a maximum $50 Canadian for out-patient services (except dialysis); and
- ☐ a maximum $210 Canadian per dialysis treatment.

During 2003-2004 emergency medically necessary out-of-country physician and other eligible practitioner services (chiropractors, dentists, optometrists, podiatrists and osteopaths) were reimbursed at the Ontario rates detailed in regulation under the HIA, or the amount billed, whichever is less. Charges for medically necessary emergency or out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed or approved hospital or health facility. Medically necessary out-of-country laboratory services when done on an emergency basis by a physician are reimbursed in accordance with the formula set out in section 29(1)(b) of the Regulation or the amount billed, whichever is less; and when done on an emergency basis by a laboratory, in accordance with the formula set out in section 31 of the Regulation.

In 2003-2004 payments for out-of-country emergency in-patient and out-patient insured hospital and medical services amounted to $41.9 million.

4.4 Prior Approval Requirement

As set out in section 28.4 of Regulation 552 of the *Health Insurance Act*, prior approval from MOHLTC is required for payment for non-emergency services provided outside of Canada. Where medically accepted treatment is not available in Ontario, or in those instances where the patient faces a delay in accessing treatment in Ontario that would threaten the patient's life or cause irreversible tissue damage, the patient may be entitled to full funding of out-of-country health services.

Under section 28.5 of Regulation 552 of the *Health Insurance Act*, laboratory tests performed outside of Canada are paid for, with prior approval from MOHLTC, if the following conditions are met:

- ☐ the kind of service or test is not performed in Ontario;
- ☐ the service or test is generally accepted in Ontario as appropriate for a person in the same circumstances as the insured person;
- ☐ the service or test is not experimental; and
- ☐ the service or test is not performed for research purposes.

In 2003-2004, total payments for prior approved treatment outside of Canada were $31.3 million. There is no formal prior approval process for services provided to Ontario residents outside of the province but within Canada. The Interprovincial Agreement on Eligibility and Portability includes a schedule for high-cost services. In rare circumstances where this schedule does not cover the costs in another province, Ontario may be asked to guarantee payment before the service is provided.

5.0 Accessibility

5.1 Access to Insured Health Services

All insured hospital, physician and surgical-dental services are available to Ontario residents on uniform terms and conditions.

All insured persons are entitled to all insured hospital and physician services, as defined in the *Health Insurance Act*.

Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations by reason of the fact that the person is not insured.

Under the *Health Care Accessibility Act* (now revoked and governed by Part II of the *Commitment to the Future of Medicare Act*) and *Health Insurance Act*, extra billing is prevented because physicians (both opt-in and opt-out) are prohibited from charging more than the amount for an insured service prescribed in the Schedule of Benefits for Physician Services. Under that same legislation, hospitals are also prohibited from charging insured residents for insured services.

MOHLTC implemented Health Number/Card Validation to aid health care providers and patients with access to health services and claim payment. Providers may subscribe for validation privileges to verify their patient eligibility and health number/version code status (card status). If patients require access to health services and do not have a health card in their possession, the provider may obtain the necessary information by submitting to MOHLTC a Health Number Release Form signed by the patient. An accelerated process for obtaining health numbers for patients who are unable to provide a health number and require emergency treatment is available to emergency room facilities through the Health Number Look Up service.

5.2 Access to Insured Hospital Services

In 2003-2004, there were 152 public hospital corporations staffed and in operation in Ontario, which included chronic, general and special rehabilitation units. There were 7,025,267 acute patient days, 2,102,449 chronic patient days and 743,590 rehabilitation patient days delivered by public hospitals during fiscal year 2003-2004.

Priority services are designated highly specialized hospital-based services that respond to life-threatening conditions. These services are often high-cost and rapidly growing which makes access of concern. Generally, these programs are managed provincially and are designed to ensure equitable access.

Priority services include:

☐ bone marrow transplantation;
☐ selected cardiovascular services;
☐ selected cancer services;
☐ end stage renal disease; and
☐ selected organ transplants.

In addition, the Ministry supports a number of major provincial strategies, including:

☐ The Ontario Stroke Strategy;
☐ Organ and Tissue Donation and Transplantation Action Plan;
☐ Visudyne Therapy Service;
☐ Ontario Joint Replacement Registry (OJRR);
☐ Telemedicine;
☐ Provincial Cancer Plan & Ontario Cancer Quality Council; and
☐ Paediatric Oncology.

5.3 Access to Insured Physician and Surgical-Dental Services

The Underserviced Area Program (UAP) is one of a number of supports provided by MOHLTC to help communities across Ontario recruit and retain health care professionals. It offers recruitment and retention tools (financial incentives) to underserviced communities. In order to access the UAP's recruitment and retention benefits, a community must be designated as underserviced.

A number of programs exist to enhance access to health care services for residents of northern and rural remote areas of Ontario:

☐ the Community Sponsored Contracts provide alternative funding arrangements that fund primary care services in communities with one or two physicians, to ensure the availability of primary care services as well as 24-hour seven days a week emergency care, where possible;
☐ the Incentive Grant Program for Physicians provides financial incentives to general practitioners and specialists who establish practice in designated underserviced areas;
☐ the Free Tuition Program provides up to $40,000 in tuition reimbursement to eligible final-year medical students, residents and newly graduated physicians in exchange for a three or four-year full-time return-of-service commitment in an underserviced community;
☐ the Northern Physician Retention Initiative, a three-year initiative, provided eligible family practitioners and specialists who maintained practices in northern Ontario for at least four years with a retention incentive as well as access to funding for continuing medical education;
☐ The Northern Group Funding Plan (NGFP) Agreements in 13 northern communities provide alternative funding arrangements for groups of between three and seven physicians to provide primary care services, as well as ensuring 24-hour seven days a week access to emergency care in local hospitals; and
☐ The Northern Health Travel Grant helps to defray transportation costs for the residents of northern Ontario who must travel long distances to access insured non-emergency hospital and specialist medical services that are not locally available and also promotes the use of specialist services located in northern Ontario, which encourages more specialists to practice and remain in the north.

Currently, there are 132 communities in Ontario designated as underserviced for general/family practitioners and 15 communities designated as underserviced for specialists.

Under the Physician Outreach Program, regularly scheduled primary care clinics may be provided to remote communities which have UAP-funded nursing stations and to provide telephone back-up to the nurse/nurse practitioners working at the nursing station.

During 2003-2004, Ontario continued to be at the forefront of Primary Care Renewal. Ontario has a number of innovative primary care delivery models. During this year the province began to align its new and existing primary care models to ensure that they all provide the same key elements including: comprehensive and preventative care, 24-hour seven days a week access through telephone advisory services, and increased after hours coverage.

5.4 Physician Compensation

Physicians are paid for the services they provide through a number of mechanisms. Most physician payments are provided through fee-for-service arrangements (>90 percent of registered physicians), with remuneration based on the Schedule of Benefits under the *Health Insurance Act*. Other physicians are paid through Alternate Payment Plans, such as capitation, global budget and volumes-based arrangements (<10 percent). In partnership with the Ontario Medical Association, the MOHLTC is implementing new payment mechanisms through primary care reform initiatives, such as Family Health Networks and Family Health Groups and new funding models for physicians in Academic Health Science Centres.

MOHLTC negotiates payment rates and other changes to the Schedule of Benefits with the Ontario Medical Association. The four-year Physician Services Agreement with the Ontario Medical Association expired on March 31, 2004. The Agreement provided an annual increase of 1.95 percent, effective April 1, 2000 and two percent for each of the following three years. The Agreement also introduces new fees aimed at easing the pressure on hospital emergency wards, providing improved access to specialists, facilitating the expansion of in-home health services and providing better care to an aging population. In addition, the Agreement included provisions for maternity benefits for female physicians.

The Agreement also committed the parties to meet in March 2003 regarding the fourth year commitments. A Memorandum of Agreement was reached in April 2003. The Memorandum of Agreement provided for additional investment beyond the previously committed funding.

In January 2004, the MOHLTC and the Ontario Medical Association commenced negotiations to develop a new agreement.

With respect to insured surgical-dental services, MOHLTC negotiates changes to the Schedule of Benefits with the Ontario Dental Association. In 2002-2003, MOHLTC and the Ontario Dental Association agreed upon a new multi-year funding agreement for dental services which became effective on April 1, 2003.

5.5 Payments to Hospitals

Hospitals submit annual Hospital Planning Brief Submissions that are the product of a broad consultation within the facilities (e.g. all levels of staff, unions, physicians and board) and within the community and region. The business plan is first and foremost a planning document but it also has a substantial budget component, both financial and statistical. The District Health Council and MOHLTC staff then review this business plan. MOHLTC's review is conducted by regional staff, specialized program staff and senior management, and follows standard guidelines. It may involve extensive discussions and clarification with the facility.

Payments made by the health care plan to hospitals for insured services and are calculated on an annual budget basis. The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority programs and cost increases in respect of above-average growth in volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

MOHLTC reviews chronic care co-payment regulations and rates annually, taking into account changes in the Consumer Price Index, Old Age Security, Guaranteed Income Supplement and Guaranteed Annual Income Supplement each year, and determines whether revisions to the regulations and rates are appropriate.

MOHLTC is beginning to measure and reward relative cost efficiency in hospitals through the Integrated Population-Based Allocation model, which also takes into consideration the individual characteristics of the hospital.

In addition, specialized methodologies are used for incremental funding for specific policy and program initiatives (i.e. Nursing Enhancements, 60-hour postpartum guarantee length of stay). Funding for hospital operations was well in excess of $10 billion for 2003-2004.

6.0 Recognition Given to Federal Transfers

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2003-2004 publications.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

MOHLTC funds 563 long-term care homes and over 68,000 beds. MOHLTC also conducts the compliance monitoring program for long-term care homes, which includes monitoring resident health and well-being, safety, security, environmental and dietary services to determine compliance with legislation, regulations and standards. MOHLTC receives and monitors the implementation of corrective action plans to achieve compliance, where necessary.

7.2 Home Care Services

Ontario home and community care programs provide a range of services that support independent community living. These services are available through Community Care Access Centres (CCAC), Community Support Service (CSS) agencies, and Children's Treatment Centres (CTC).

CCACs provide simplified access for eligible Ontario residents of all ages to community-based health care and support services. CCACs assess individual care needs and arrange professional and personal support services in the home or school. CCACs also provide information and refer persons to other community services and arrange admission to institutional care when necessary.

Community Support Service (CSS) agencies provide support services, including homemaking, attendant care, adult day programs, caregiver support, meal services, home maintenance and escorted transportation. These services complement in-home and other health services and the assistance provided by family and friends.

Children receive out-patient rehabilitative and habilitative therapy services from Children's Treatment Centres. All CTCs provide occupational therapy, physiotherapy, and speech-language pathology services. A wide range of other services may be provided, depending on community needs and the availability of other services locally. Children too ill to leave home are served through CCAC in-home services.

Registered Persons					
	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#)	11,400,000	11,700,000	11,800,000	12,100,000	12,200,000

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
2. Number (#):					
a. acute care	154	150	139	139	139
b. chronic care	12	12	11	11	11
c. rehabilitative care	4	4	4	4	4
d. other	3	3	3	3	3
e. total	173[1]	169[1]	157[1]	157[1]	157[1]
3. Payments ($):					
a. acute care	not available[2]	not available[2]	not available[2]	not available[2]	not available[2]
b. chronic care	not available[2]	not available[2]	not available[2]	not available[2]	not available[2]
c. rehabilitative care	not available[2]	not available[2]	not available[2]	not available[2]	not available[2]
d. other	not available[2]	not available[2]	not available[2]	not available[2]	not available[2]
e. total	7,700,000,000	8,700,000,000	9,200,000,000	10,300,000,000	10,300,000,000
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
b. diagnostic imaging facilities	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
c. total	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
5. Number of insured hospital services provided (#):					
a. surgical facilities	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
b. diagnostic imaging facilities	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
c. total	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
6. Payments ($):					
a. surgical facilities	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
b. diagnostic imaging facilities	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
c. total	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	10,227	10,281	10,395	10,508	10,611
b. specialists	10,284	10,392	10,520	10724	10,703
c. other	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
d. total	20,511	20,673	20,915	21232	21,314
8. Number of opted-out physicians (#):					
a. general practitioners	25	25	22	17	15
b. specialists	188	177	165	134	114
c. other	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
d. total	213	202	187	151	129
9. Number of not participating physicians (#):					
a. general practitioners	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
b. specialists	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
c. other	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
d. total	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
10. Number of services provided through fee for service (#):					
a. general practitioners	79,600,000	79,700,000	77,800,000	76,800,000	78,700,000
b. specialists	91,400,000	93,600,000	99,600,000	102,300,000	103,300,000
c. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
d. total	171,000,000	173,300,000	177,400,000	179,100,000	182,000,000
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	1,725,200,000	1,734,100,000	1,741,400,000	1,733,200,000	1,820,200,000
b. specialists	2,699,200,000	2,824,300,000	2,936,700,000	3,065,100,000	3,152,800,000
c. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
d. total	4,424,400,000	4,558,400,000	4,678,100,000	4,798,300,000	4,973,000,000
12. Average payment per fee for service service ($):					
a. general practitioners	21.67	21.77	22.40	22.57	23.14
b. specialists	29.53	30.19	29.50	29.96	30.52
c. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
d. all services	25.87	26.32	26.40	26.79	27.33
13. Number of services provided through all payment methods (#):					
a. medical	84,100,000	82,900,000	81,800,000	81,800,000	80,900,000
b. surgical	2,200,000	22,300,000	22,700,000	23,900,000	27,100,000
c. diagnostic	64,800,000	68,100,000	72,900,000	73,400,000	74,000,000
d. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
e. total	170,900,000	173,300,000	177,400,000	179,100,000	182,000,000
14. Total payments to physicians paid through all payment methods ($):					
a. medical	2,678,600,000	2,699,800,000	2,731,400,000	2,742,800,000	2,818,000,000
b. surgical	633,800,000	670,800,000	706,800,000	735,000,000	787,700,000
c. diagnostic	1,112,000,000	1,187,800,000	1,239,800,000	1,320,500,000	1,367,300,000
d. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
e. total	4,424,400,000	4,558,400,000	4,678,100,000	4,798,300,000	4,973,000,000
15. Average payment per service, all payment methods ($):					
a. medical	31.84	32.59	33.40	33.53	34.84
b. surgical	28.78	30.09	31.10	30.75	29.04
c. diagnostic	17.15	17.45	17.00	17.99	18.48
d. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
e. all services	25.87	26.32	26.40	26.79	27.33

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
16. Total number of claims, in-patient (#).	9,031	9,540	8,633	9,306	9,023
17. Total number of claims, out-patient (#).	155,648	161,882	144,831	140,692	167,143
18. Total payments, in-patient ($).	41,300,000	39,900,000	36,800,000	48,500,000	63,000,000
19. Total payments, out-patient ($).	18,700,000	22,000,000	18,000,000	16,500,000	20,000,000
20. Average payment, in-patient ($).	4,573.00	4,182.00	4,262.70	5,211.70	6,982.00
21. Average payment, out-patient ($).	120.00	136.00	124.30	117.30	119.66
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	455,136	433,463	469,146	497,880	557,720
23. Total payments ($).	14,000,000	14,400,000	15,500,000	17,700,000	18,600,000
24. Average payment per service ($).	31.00	33.00	33.00	35.00	33.34

Insured Services Provided Outside Canada					
Hospitals	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
25. Total number of claims, in-patient (#).	20,657	20,503	18,542	23295	21,458
26. Total number of claims, out-patient (#).	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
27. Total payments, in-patient ($).	17,000,000	18,800,000	19,300,000	27,200,000	32,000,000
28. Total payments, out-patient ($)	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
29. Average payment, in-patient ($).	823.00	918.00	1,043.20	1,167.40	1,490.80
30. Average payment, out-patient ($).	not available [9]	not available [9]	not available [9]	not available [9]	not available [9]
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	184,107	179,679	157,191	200428	180,395
32. Total payments ($).	11,600,000	15,500,000	8,200,000	10,200,000	9,900,000
33. Average payment per service ($).	63.00	86.00	51.90	51.00	55.10

Insured Surgical-Dental Services Within Own Province or Territory					
	1999-2000	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
34. Number of particpating dentists (#).	350	357	327	319	323
35. Number of services provided (#).	69,400	71,660	74,000	75600	72,900
36. Total payments ($).	8,100,000	8,200,000	8,600,000	9,300,000	9,200,000
37. Average payment per service ($).	116.71	115.21	116.00	123.02	126.20

Endnotes

1. Excludes the three Provincial Psychiatric Hospitals.
2. Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of bed. Separating by facility type gives a small sample size and significantly understates the amount actually spent on chronic and rehabilitative beds.
3. Data is not collected within a single system in the ministry.
4. All physicians are categorized as general practitioner or specialist.
5. Ontario has no non-participating physicians, only opted-out physicians who are reported under item #8.
6. All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.
7. Included in #25.
8. Included in #27.
9. Included in #29.

Manitoba

Introduction

Manitoba Health provides leadership and support to protect, promote and preserve the health of all Manitobans. The Department is organized into five distinct but related functional areas: Finance, Regional Affairs, Provincial Health Programs, Health Accountability, Policy and Planning, and Health Workforce. Their mandates are derived from established legislation and policy pertaining to health and wellness issues. The roles and responsibilities of Manitoba Health include policy, program and standards development, fiscal and program accountability and evaluation.

On November 4, 2003, a new Cabinet position, Minister of Healthy Living, was announced. This has created additional profile and focus on Manitoba Health's goals related to promoting and maintaining good health.

Health services are delivered through 11 Regional Health Authorities, hospitals and other health care facilities.

Manitoba Health continues to improve the quality of the health care system and meet the public's expectations by working to reduce waiting lists, to provide service enhancements and to recruit and retain health care professionals. Other strategic challenges are to provide services to maintain the quality of life for Manitobans living with chronic diseases, to reform mental health services, Pharmacare, primary health care and to invest in continuing care. In addition, Manitoba Health continues to improve access to care and to reduce waitlists for services through a variety of strategies that include a broader influenza vaccination program and better coordination of hospital resources. Other measures to reduce the demand for hospital beds include ambulatory care initiatives, community access centres and home care and long-term care investments.

Mental Health Renewal, which began in 2001, highlights mental health within the health system and focuses on improved integration of mental health services within the primary health care system; enhanced consumer and family participation in the design and delivery of mental health services; improved public understanding of mental illness and mental wellness; and the importance of early identification and intervention.

Manitoba's Pharmacare Program has been enhanced by adding new drugs to the formulary, streamlining administration and interacting with other provinces regarding common approaches, such as a common drug review mechanism.

Patient safety and quality care continue to be high priorities for Manitoba Health. An integrated patient safety strategy based on priorities identified by the National Patient Safety Steering Committee and the recommendations of the Sinclair Inquiry[1] and Thomas Report[2] is under development.

Overall, Manitoba Health is building a culture of accountability for both the work of the Department of Health and the work of various stakeholders in the health care system.

Clarifying roles and responsibilities of partners and expectations for performance is essential to strengthening accountability relationships. Early in 2003, Manitoba Health initiated a process of developing annual performance agreements with the Regional Health Authorities, CancerCare

---

[1] The Sinclair Inquiry (Pediatric Cardiac Surgery Inquest) was tasked with conducting an inquiry into the deaths of 12 infants in cardiac care in Winnipeg. Associate Chief Justice Murray Sinclair headed the inquiry and wrote the recommendations contained in the Pediatric Cardiac Surgery Inquest Report.

[2] University of Manitoba Prof. Paul Thomas headed the Review and Implementation Committee that was appointed to respond to the recommendations of the Sinclair Inquiry.

Manitoba and the Addictions Foundation of Manitoba. These agreements provide clear direction regarding performance deliverables in key areas and outline how such performance will be monitored and measured. The first agreements were signed in spring 2003 for the 2003-2004 fiscal year.

The Role and Mission of Manitoba Health

Manitoba Health is a line department within the government structure and operates under the provisions of statutes and responsibilities charged to the Ministers of Health and Healthy Living. The formal mandates contained in legislation, combined with mandates resulting from responses to emerging health and health care issues, establish a framework for planning and delivering services.

It is Manitoba Health's vision to lead the way in quality health care, built with creativity, compassion, confidence, trust and respect to empower Manitobans through knowledge, choices and access to the best possible health resources, and to build partnerships and alliances for health and supportive communities.

It is the mission of Manitoba Health to lead a health care system that meets the needs of Manitobans and to promote their health and well-being. This is accomplished through a structure of comprehensive envelopes encompassing program, policy and fiscal accountability; by the development of a healthy public policy; and by the provision of appropriate, effective and efficient health and health care services. Services are provided through regional delivery systems, hospitals and other health care facilities. The Department also makes payments on behalf of Manitobans for insured health benefits related to the costs of medical, hospital, personal care, Pharmacare and other health services.

It is also the role of Manitoba Health to foster innovation in the health care system. This is accomplished by developing mechanisms to assess and monitor quality of care, utilization and cost-effectiveness; fostering behaviours and environments that promote health; and promoting responsiveness and flexibility of delivery systems and alternative, less expensive services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by the Department of Health under the *Health Services Insurance Act*, R.S.M. 1987, c. H35. The Act[3] was significantly amended in 1992, dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to Manitoba Health. The dissolution took effect on March 31, 1993.

The MHSIP is administered under this Act for insurance in respect of the costs of hospital, personal care and medical and other health services referred to in acts of the Legislature or regulations thereunder. The Act was amended on January 1, 1999, to provide insurance for out-patient services relating to insured medical services provided in surgical facilities.

The Minister of Health is responsible for administering and operating the Plan. Under section 3(2), the Minister has the power:

- ☐ to provide insurance for residents of the province in respect of the costs of hospital, medical and other health services, and personal care;
- ☐ to plan, organize and develop throughout the province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the province;
- ☐ to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including

---

[3] Where reference is made to "the Act" in the text, this refers to the *Health Services Insurance Act* (1999).

standards concerning supervision, licensing, equipment and inspection, or to make such arrangements that the Minister considers necessary to ensure that adequate standards are maintained;

☐ to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the province or to make such arrangements that the Minister considers necessary to ensure that such a consulting service is provided;

☐ to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns relating to hospitals, which are required by the Government of Canada, are submitted; and

☐ in cases where residents do not have available medical and other health services, to take such measures that are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents.

The Minister may also enter into contracts and agreements with any person or group that he or she considers necessary for the purposes of the Act. The Minister may also make grants to any person or group for the purposes of the Act on such terms and conditions that are considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the Regulations.

There were no legislative amendments to the Act or the Regulations in the 2003-2004 fiscal year that affected the public administration of the Plan.

1.2 Reporting Relationship

Section 6 of the Act requires the Minister to have audited financial statements of the Plan showing separately the expenditures for hospital services, medical services and other health services. The Minister is required to prepare an annual report, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it, if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of the Act requires that the Office of the Auditor General of Manitoba (or another auditor designated by the Office of the Auditor General of Manitoba) audit the accounts of the Plan annually and prepare a report on that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2003-2004 fiscal year and is contained in the *Manitoba Health Annual Report, 2003-2004.*

2.0 Comprehensiveness

2.1 Insured Hospital Services

Sections 46 and 47 of the Act, as well as the Hospital Services Insurance and Administration Regulation (M.R. 48/93), provide for insured hospital services.

As of March 31, 2004, there were 98 facilities, including one provincial psychiatric centre in Manitoba, providing insured hospital services to both in- and out-patients. Hospitals are designated by the Hospitals Designation Regulation (M.R. 47/93) under the Act.

Services specified by the Regulation as insured in and outpatient hospital services include:

☐ accommodation and meals at the standard ward level;

☐ necessary nursing services;

☐ laboratory, radiological and other diagnostic procedures;

☐ drugs, biologics and related preparations;

☐ routine medical and surgical supplies;

☐ use of operating room, case room and anaesthetic facilities; and

☐ use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

All hospital services are added to the list of available hospital services through the health planning process.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations. Manitoba Health is sensitive to new developments in the health sciences.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the Medical Services Insurance Regulation (M.R. 49/93) made under the Act.

Physicians providing insured services in Manitoba must be lawfully entitled to practise medicine in Manitoba, registered and licensed under the *Medical Act*. As of March 31, 2004, there were 2,124 physicians on the Manitoba Health Registry.

A physician, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, in accordance with section 91 of the Act and section 5 of the Medical Services Insurance Regulation. The election to opt out of the health insurance plan takes effect on the first day of the month following a 90-day period from the date the Minister receives the notice.

Before rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or Regulations. To date, no physicians have opted out of the medical plan in Manitoba.

The range of physician services insured by Manitoba Health is listed in the Payment for Insured Medical Services Regulation (M.R. 95/96). Coverage is provided for all medically required personal health care services, rendered to an insured person by a physician that are not excluded under the Excluded Services Regulation (M.R. 46/93) of the Act. During fiscal year 2003-2004, a number of new insured services were added to a revised fee schedule.

In order for a physician's service to be added to the list of those covered by Manitoba Health, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). The proposals are forwarded to the Manitoba College of Physicians and Surgeons for review to ensure the service is scientifically valid and not developmental or experimental. The MMA will negotiate the item, including the fee, with Manitoba Health. Manitoba Health may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93) under the Act. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This Regulation also provides benefits relating to the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthday, when provided by a registered orthodontist. As of March 31, 2004, 570 dentists were registered with Manitoba Health.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and may not charge to or collect from an insured person a fee in excess of the benefits payable under the Act or Regulations. No providers of dental services had opted out as of March 31, 2004.

In order for a dental service to be added to the list of insured services, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA will negotiate the fee with Manitoba Health.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

The Excluded Services Regulation (M.R. 46/93) made under the Act sets out those services that are not insured. These include:

- ☐ examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties;
- ☐ group immunization or other group services except where authorized by Manitoba Health;
- ☐ services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependants;
- ☐ preparation of records, reports, certificates, communications and testimony in court;
- ☐ mileage or travelling time;
- ☐ services provided by psychologists, chiropodists and other practitioners not provided for in the legislation;
- ☐ *in-vitro* fertilization;
- ☐ tattoo removal;
- ☐ contact lens fitting;
- ☐ reversal of sterilization procedures; and
- ☐ psychoanalysis.

The Hospital Services Insurance and Administration Regulation states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The Regional Health Authorities and Manitoba Health monitor compliance.

All Manitoba residents have equal access to services. Third parties such as private insurers or the Workers Compensation Board do not receive priority access to services through additional payment. Manitoba has no formalized process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows Regional Health Authorities and Manitoba Health to monitor usage and service concerns.

To de-insure services covered by Manitoba Health, the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health in 2003-2004.

3.0 Universality

3.1 Eligibility

The *Health Services Insurance Act* defines the eligibility of Manitoba residents for coverage under the provincial health care insurance plan. Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, resides in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a Minister's permit under the *Immigration Act* (Canada), unless the Minister determines otherwise, or is a visitor, transient or tourist.

The Residency and Registration Regulation (M.R. 54/93) extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have an employment authorization of 12 months or more.

The Residency and Registration Regulation, section 6, defines Manitoba's waiting period as follows:

> "A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival."

There are currently no other waiting periods in Manitoba.

The MHSIP excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civilian War-related Benefits Act*; *Government Employees Compensation Act*; *Merchant Seaman Compensation Act*; *National Defence Act*; *Pension Act*; *Royal Canadian Mounted Police Act*; or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The excluded are residents who are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP) and federal inmates. These residents become eligible for Manitoba Health coverage upon discharge from the Canadian Forces, the RCMP, or if an inmate of a penitentiary has no resident dependants. Upon change of status, these persons have one month to register with Manitoba Health (Residency and Registration Regulation (M.R. 54/93, subsection 2(3)).

3.2 Registration Requirements

The process of issuing health insurance cards requires that individuals inform Manitoba Health that they are legally entitled to be in Canada, and that they intend to be physically present in Manitoba for six months. They must also provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a registration certificate for the individual and all qualifying dependants.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependant. This number is used by Manitoba Health to pay for all hospital and medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for the provincial drug program.

As of March 31, 2004, there were 1,159,784 residents registered with the health care insurance plan.

There is no provision for a resident to opt-out of the Manitoba health plan.

3.3 Other Categories of Individual

The Residency and Registration Regulation (M.R. 54/93, sub-section 8(1)) requires that temporary workers possess a work permit issued by Citizenship and Immigration Canada (CIC) for at least 12 months, be physically present in Manitoba and be legally entitled to be in Canada before receiving Manitoba Health coverage.

As of March 31, 2004, there were 3,234 individuals on work permits covered under the MHSIP.

The definition of "resident" under the *Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration Act* (Canada).

No legislative amendments to the Act or the Regulations in the 2003-2004 fiscal year affected universality.

4.0 Portability

4.1 Minimum Waiting Period

The Residency and Registration Regulation (M.R. 54/93, section 6) identifies the waiting period for insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arriving in Manitoba is entitled to benefits on the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation (M.R. 54/93 section 7(1)) defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their full-time enrollment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies.

Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals must return and reside in Manitoba after completing their leave.

Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan residents who receive care in Manitoba border communities.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in- patient, high-cost procedures and out-patient services are based on national rates agreed to by provincial or territorial health plans. These include all medically necessary services as well as costs for emergency care.

Except for Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient or physician to Manitoba Health for payment at host province rates.

In 2003-2004, Manitoba Health made payments of approximately $20,660,315 for hospital services and $7,579,028 for medical services provided in Canada.

4.3 Coverage During Temporary Absences Outside Canada

The Residency and Registration Regulation (M.R. 54/93, sub-section 7(1)) defines the rules for portability of health insurance during temporary absences from Canada.

Residents on full-time employment contracts outside Canada will receive Manitoba Health coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba after completing their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health for up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrollment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba after completing their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93). Hospital services received outside Canada due to an emergency or a sudden illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per-diem rate according to hospital size:

☐ 1-100 beds:	$280
☐ 101-500 beds:	$365
☐ over 500 beds:	$570

Out-patient services are paid at a flat rate of $100 per visit or $215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in both rural and urban areas.

Manitobans requiring medically necessary hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for costs incurred in the United States by providing Manitoba Health with a recommendation from a specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at no less than 100 percent of the equivalent Manitoba rate for similar services. Hospital services are paid at up to 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds (the Hospital Services Insurance and Administration Regulation, sections 15-23).

Manitoba Health made payments of approximately $2,564,221 for hospital care provided in hospitals outside Canada in the 2003-2004 fiscal year. In addition, Manitoba Health made payments of approximately $519,782 for medical care outside Canada.

In instances where Manitoba Health has given prior approval for services provided outside Canada and payment is less than 100 percent of the amount billed for insured services, Manitoba Health will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval is not required for services provided in other provinces or territories. Prior approval is required for elective hospital and medical care provided outside Canada. An appropriate medical specialist must apply to Manitoba Health to receive approval.

No legislative amendments to the Act or the Regulations in the 2003-2004 fiscal year had an effect on portability.

5.0 Accessibility

5.1 Access to Insured Health Services

Manitoba Health ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the Surgical Facilities Regulation (M.R. 222/98) under The *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees for insured medical services.

In July 2001, the *Health Services Insurance Act*, the *Private Hospitals Act* and the *Hospitals Act* were amended to strengthen and protect public access to the health care system. The amendments include:

☐ changes to definitions and other provisions to ensure that no charges can be made to individuals who receive insured surgical services or to anyone else on that person's behalf; and

☐ ensuring that a surgical facility cannot perform procedures requiring overnight stays and thereby function as a private hospital.

On February 10, 2004, Manitoba officially opened the expanded Health Links/Info Santé, a 35-seat, state-of-the-art call centre with a call capacity of 300,000 per year.

Manitobans now have access to vital health information and assistance in 110 languages 24-hours a day, seven days a week.

Public demand for Health Links/Info Santé has increased steadily since it began as a six station call centre in 1994. Manitobans value the service. Providing this information source relieves pressure on other areas of the health care system, particularly emergency rooms.

Through the Primary Health Care Transition Fund Multi-jurisdictional Envelope funds have been made available to implement a program to manage patients with congestive heart failure. Beginning in November 2004, this 17-month initiative will evaluate the benefits of using health lines to manage patients with chronic diseases.

5.2 Access to Insured Hospital Services

All Manitobans have access to hospital services including acute care, psychiatric extended treatment, mental health, palliative, chronic, long-term assessment/rehabilitation and to personal care facilities. There has been a shift in focus from hospital beds to community services, out-patients and day surgeries, which are also insured services.

As a result of investments in nursing education, Manitoba's nursing shortage has improved significantly in Winnipeg, with a more gradual improvement noted in rural and northern regions over the past year. Interest in nursing education continues to be high.

Manitoba also has a wide range of other health care professionals. Shortages in some of the technology fields such as nuclear medicine, medical radiation and laboratory technology continue to be an issue.

Manitoba currently has access to four Magnetic Resonance Imaging (MRI) machines for clinical testing. All units are in Winnipeg. The first unit was installed in 1990 by the St. Boniface Research Foundation and replaced in October 1998. The second, located at the Health Sciences Centre, began operating in September 1998. This unit was a joint initiative with the National Research Council (NRC). A third unit began operating in January 2000. The fourth and newest MRI, located at the Health Sciences Centre, began operating in March 2004.

Manitoba has 17 Computerized Tomography (CT) scanners: three (one for paediatric patients) at the Health Sciences Centre, two at the St. Boniface General Hospital, one each at Victoria General Hospital, Dauphin Regional Health Centre, Thompson General Hospital, Brandon Regional Health Centre, Boundary Trails Health Centre, Misericordia Health Centre, Seven Oaks, Grace and Concordia Hospitals, and newly installed scanners in Steinbach and Selkirk. The newest CT scanner, located in The Pas, began operating in October 2003. One of the scanners at the Health Sciences Centre was replaced and one scanner was upgraded, both by 16-slice scanners. As well, ultrasound scanners are located in seven Winnipeg health facilities and 16 rural and northern health facilities. Bone density testing is funded by Manitoba Health on two machines located in Winnipeg and Brandon.

In March 2003, CancerCare Manitoba completed the opening of their 205,000 square foot world-class facility for treatment, education and research with an on-site laboratory for the Manitoba Institute of Cell Biology. The Manitoba School of Radiation Technology now has classroom space in the new CancerCare facility. In January 2004, seven students graduated from the Manitoba School of Radiation Therapy and two were retained by CancerCare Manitoba. The next class will graduate in January 2005.

Prostate brachytherapy treatment began in April 2003 at CancerCare Manitoba. This treatment will reduce the number of patients on the waiting list and, therefore, will reduce the waiting time for radiation therapy.

Gamma Knife Neurosurgery was established in November 2003. It provides patients with an opportunity for alternative treatment to conventional radiotherapy, linear accelerator-based treatments and certain microsurgeries.

Manitoba Health allocated funding to a Cardiac Critical Shortages Fund to send patients, who have waited longer for medically recommended surgery, out-of-province for cardiac surgery, if they so choose. No patients on the cardiac surgery waitlist chose the option of being sent out-of-province. Targeted funding was provided to Regional Health Authorities to address specific capacity issues including funding to increase diagnostic and surgical procedures such as cataract surgery, orthopaedic surgery and cardiac surgery.

Manitoba is a partner in the Western Canada Waiting List project. The Winnipeg Regional Health Authority is implementing and evaluating two of the tools developed through this project: the Child and Adolescent Mental Health tool and the General Surgery tool. The Child and Adolescent Mental Health tool project team has developed priority criteria and forms were entered into a computerized database. Centralized Intake staff have been trained to complete priority forms on line. The priority criteria score is used as an assessment tool to prioritize child and adolescent mental health clients.

The Emergency Care Task Force was initiated in January 2004 to develop and oversee the implementation of recommendations for the short- and long-term improvement of emergency care in Winnipeg hospitals.

5.3 Access to Insured Physician and Surgical-Dental Services

In 2003-2004, Manitoba Health continued to support initiatives to improve access to physicians in rural and northern areas of the province. In October 2003, Manitoba supported a co-ordinated process to assist with changes in recruiting foreign-trained physicians to rural regions, as a result of changes in the regulation for registration of medical practitioners in early 2003. Issues addressed through the co-ordinated process include the immigration process and clinical assessment processes, as well as other issues related to eligibility criteria for conditional medical registration.

The co-ordinated process will help Regional Health Authorities with the logistics of recruiting foreign-trained physicians and avoid duplication of effort. It will introduce future physician candidates to opportunities available in Manitoba. The process will also explore possible new markets made available through the new legislation around physician licensure.

A Recruitment Co-ordinator was recruited by the Regional Health Authorities of Manitoba, Inc. to support this initiative effective on October 20, 2003.

Manitoba continues to experience a small increase in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province continued to provide a financial assistance grant for students and residents. In return for financial assistance during their training, the student or resident agrees to work in Manitoba for a specific period after graduating. The program was introduced in May 2001. There are plans to expand the program to include family doctors from outside Manitoba and family doctors who have left the province and want to return. Increased enrolment in the undergraduate medical program at the University of Manitoba is under consideration and is being discussed with the Manitoba Department of Advanced Education and Training.

The Manitoba Telehealth Network under the leadership of the Winnipeg Regional Health Authority has implemented the infrastructure to link 23 Telehealth sites across the province. This modern telecommunications link means patients can be seen by specialists and medical staff can consult with each other without having to endure the expense and inconvenience of travelling from the North to Winnipeg. In September 2002, Manitoba Health launched the new Manitoba Telehealth site at St. Boniface General Hospital, officially linking its medical specialists to patients and colleagues province-wide.

5.4 Physician/Dentist Compensation

Manitoba continues to employ the following methods of payment for physicians: fee-for-service, salaried, sessional and blended.

Fee-for-service remains the dominant method of payment for physician services. Notwithstanding, alternate payment arrangements constitute a significant portion of the total compensation to physicians in Manitoba. Alternate-funded physicians are those who receive either a salary (employer-employee relationship) or those who work on an independent contract. Manitoba also uses blended payment methods to "top-up" the wages of physicians whose fee-for-service income may not be competitive, yet whose services remain vital to the province. As well, physicians may receive sessional payments for providing medical services, as well as stipends for on-call responsibilities.

Representatives from the Manitoba Medical Association (MMA) and Manitoba Health typically negotiate compensation agreement for physicians. Representatives from Manitoba Health and the Manitoba Dental Association (MDA) are usually involved in negotiating agreements with dental surgeons, oral surgeons and periodontists.

The Health Services Insurance Act governs payment to both physicians and dentists/oral surgeons for insured services.

There were no amendments to the *Health Services Insurance Act* (HSIA) during the 2003-2004 fiscal year.

Manitoba Health and the MDA negotiated an agreement that covers the period of April 1, 2002 to March 31, 2005. The agreement includes the following:

- fee increases to the Oral Surgery Schedule, Cleft Lip/Palate Schedule and Assistant Surgeons' Fee Schedule (3 percent on April 1, 2002; 3 percent on April 1, 2003; and 3 percent on April 1, 2004, non-compounded);
- introduction of 10 new tariffs;
- amendment to five existing tariffs; and
- deletion of 14 tariffs.

On June 2, 2002, Manitoba Health and the MMA signed an arbitration agreement for fee-for-service and alternate funded physicians.

In accordance with the June 2, 2002 Arbitration Agreement between Manitoba Health and the MMA, the issue of an overall award for fee-for-service physician services was referred to a three-person Board of Arbitration in February 2003.

On June 23, 2003 the parties reached a comprehensive negotiated settlement for all fee-for-service and alternate funded physicians represented by the MMA. This terminated the arbitration process.

The settlement maintained the terms of the June 2, 2002 Arbitration Agreement, including:

- the establishment of a Physician Retention Fund ($5 million per annum over the duration of this agreement as well as the subsequent agreement);
- the continuation of the Professional Liability Insurance Fund ($5 million per annum for calendar years 2003, 2004, 2005 and 2006);
- the continuation of the Continuing Medical Education Fund ($1 million per annum for the calendar years 2002, 2003 and 2004);
- the establishment of a Maternity/Parental Benefits Fund ($1 million per annum for calendar years 2002, 2003 and 2004);
- a mechanism to initiate arbitration proceedings with respect to a subsequent agreement, if notice is given by either party by January 1, 2005;
- physicians covered by the Agreement shall refrain from stoppage of work or curtailment of services and to continue to provide services without interruption; and
- continuation of the Grievance Arbitration procedure set forth in the March 8, 1994 Fee-For-Service Agreement between the parties.

The highlights of the June 23, 2003 Negotiated Settlement include:

- a three-year term from April 1, 2002 to March 31, 2005;
- an overall increase of 9 percent (non-compounded) to the Fee-For-Service Schedule of Benefits, as well as alternate-funded agreements/arrangements) – 3 percent effective October 1, 2002; 3 percent effective April 1, 2003; and 3 percent effective April 1, 2004;
- an additional $10 million ($5 million effective April 1, 2003 and $5 million effective April 1, 2004) was applied to the schedule of benefits. Approximately $7 million of the $10 million has been applied to the fee tariffs for family physicians. The remaining $3 million was used to address fee and income disparities in the other blocs of practice, such as Rheumatology, Physical Medicine, Geriatric Medicine, etc.;
- an extension of maternity and parental benefits to all Manitoba physicians, including interns and residents;
- increased incentives for family doctors to provide full-service care and to maintain hospital privileges;
- the incremental cost of this increase was approximately $38 million for fee-for-service physicians (exclusive of increases in volume). Of this amount, over 50 percent was allocated to the fee tariffs for family physician; and
- increases to the rates for physicians under alternate funding agreements in the amount of 3 percent effective October 1, 2002; 3 percent effective April 1, 2003; and 3 percent effective April 1, 2004 (non-compounded) were also applied over and above the fee-for-service increase.

5.5 Payments to Hospitals

Division 3.1 of Part 4 of the *Regional Health Authorities Act* sets out the requirements for operational agreements between Regional Health Authorities and the operators of hospitals and personal care homes, defined as "health corporations" under the Act.

Pursuant to the provisions of this division, Authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that enables the health services to be provided by the health corporation, the funding to be provided by the Authority for the health services, the term of the agreement and a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request that the Minister of Health appoint a mediator to help them resolve outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute. The Minister's resolution is binding on the parties.

The Regional Health Authorities have concluded the required agreements. The operating agreements between the Winnipeg Regional Health Authority and the health corporations operating facilities in Winnipeg will expire on March 31, 2006. The operating agreements enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities.

In addition to the Winnipeg Regional Health Authority, there are two other Regional Health Authorities that continue to have hospitals operated by health corporations in their health regions. In all other regions, the hospitals are operated by the Regional Health Authorities or by the federal government. The agreements in place between the Authorities and the health corporations do not have expiry dates. The Authorities are empowered to determine the funding to be provided each year.

The allocation of resources by Regional Health Authorities for providing hospital services is approved by Manitoba Health through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act*. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of the *Health Services Insurance Act*, payments from the MHSIP for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

No legislative amendments to the Act or the Regulations in 2003-2004 had an effect on payments to hospitals.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health and Social Transfer (CHST) in public documents.

7.0 Extended Health Care Services

Manitoba has established community-based service programs as appropriate alternatives to hospital services. These service programs are provided by Manitoba Health through the Regional Health Authorities. The services include the following:

Personal Care Home Services

The Personal Care Services Insurance and Administration Regulation under the *Health Services Insurance Act* authorizes the provision of services to personal care homes. Both proprietary and non-proprietary homes are licensed by Manitoba Health. Residents of personal care homes also pay a residential charge. The total Manitoba Health operating expenditures for personal care services during fiscal year 2003-2004 amounted to $410,806,691, supporting a total of 9,597 licensed set-up personal care beds. In addition, there were estimated capital and equipment expenditures of $21,040,157.

Home Care Services

The Manitoba Home Care Program is the oldest comprehensive, province-wide, universal home care program in Canada. Manitoba Home Care provides effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the local offices of the Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs. Services may be co-ordinated by a Case Co-ordinator or are self/family-managed and may include personal care assistance, home support, health care, family relief, respite care, supplies and equipment, adult day programs and/or volunteer services.

Mental Health and Addictions Services

All Regional Health Authorities provide community mental health services. Community Mental Health Workers provide assessment, service planning, short-term counselling interventions, rehabilitation and recovery planning, crisis intervention, community consultation and education. In addition to community mental health workers, some regions have a variety of intensive and supportive programs such as Intensive Case Management, Supported Employment, Supported Housing and, in Winnipeg, the Program for Assertive Community Treatment and the Early Psychosis Prevention and Intervention Service.

Addictions services and supports are provided through provincially funded agencies, the largest being the Addictions Foundation of Manitoba; however, there are several other addictions agencies funded by Manitoba Health. These agencies work to reduce the harm associated with alcohol, other drugs and gambling through education, prevention, rehabilitation and research.

Primary Health Care

In 2003-2004, each Regional Health Authority developed and submitted a regional primary health care (PHC) operational plan to the Manitoba government.

These plans are based on the findings of regional community health assessments, include implementation and communication strategies, measurable outcomes and alignment with the Province's PHC Policy Framework (approved April 9, 2002).

With the federal Primary Health Care Transition Fund (PHCTF) per capita allocation, Manitoba Health developed a two-phase approach to developing PHC in Manitoba.

Phase 1 focused on five initiatives to address challenges to the effective delivery of PHC and provide a foundation for future Regional Health Authority-based reforms.

Phase 2 provided PHCTF dollars for initiatives developed by the Regional Health Authorities in partnership with key stakeholders. Seventeen projects were approved. Themes for the initiatives include service integration, community access to primary care, interdisciplinary training, change management techniques, community capacity building, information technology and capital infrastructure.

A provincial standard for the provision of midwifery care was introduced in 2002. The standard provides provincial direction in terms of annual workload, service levels for priority population clients, and requirements that the midwives be integrated into the Regional Health Authority health care system. Midwifery resources in Manitoba comprise 30 midwives working in nine practice groups in six Regional Health Authorities.

In 1999, the Manitoba government approved-in-principle the Winnipeg Regional Health Authority's concept for the Health Access Model based on the principles of primary health care. Key components of the centres are service integration, primary care clinics and the organizational infrastructure to facilitate timely, efficient and cost-effective services to the local community. Access River East opened to the public in February 2004. Access Transcona and Access Inkster are in the planning stages.

Ambulatory Health Care Services

The *Health Services Insurance Act* includes a provision authorizing the designation of non profit publicly administered ambulatory health (primary care) centres as institutions within the meaning of the Act.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#)[1]	1,144,424	1,149,904	1,152,982	1,156,217	1,159,784

Insured Hospital Services Within Own Province or Territory

Public Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
2. Number (#):					
a. acute care	95	95	96	92	92
b. chronic care	4[2]	3[2]	3[2]	5[2]	5[2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not applicable	not applicable	not applicable	not available	not available
e. total	99	98	99	97	97
3. Payments ($):					
a. acute care	not available	953,834,797	1,046,407,229	1,148,652,940	1,220,253,362
b. chronic care	not available	65,153,895	70,872,152	107,840,132	117,642,127
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	not applicable	not applicable	not applicable	1	1
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	0	0
c. total	not applicable	not applicable	not applicable	1	1
5. Number of insured hospital services provided (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not available	not available
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	0	0
c. total	not applicable	not applicable	not applicable	not available	not available
6. Payments ($):					
a. surgical facilities	not applicable	not applicable	not applicable	not available	1,252,657
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	0	0
c. total	not applicable	not applicable	not applicable	not available	1,252,657

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	915	948	not available	954	959
b. specialists	939	not available	not available	1,010	980
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,854	not available	not available	1,964	1,939
8. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
9. Number of not participating physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
10. Number of services provided through fee for service (#):					
a. general practitioners	5,931,022	6,211,011	6,244,197	6,161,451	6,224,463
b. specialists	8,147,749	8,741,628	9,198,787	9,779,269	10,044,381
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	14,078,771	14,952,639	15,442,984	15,940,720	16,268,844
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	114,868,502	132,200,004	140,703,474	143,846,209	152,393,920
b. specialists	178,359,474	199,231,274	214,392,377	221,948,290	232,153,861
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	293,227,976	331,431,278	355,095,851	365,794,499	384,547,781
12. Average payment per fee for service service ($):					
a. general practitioners	19.37	21.28	22.53	23.35	24.48
b. specialists	21.89	22.79	23.31	22.70	23.11
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	20.83	22.17	22.99	22.95	23.64
13. Number of services provided through all payment methods (#):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
14. Total payments to physicians paid through all payment methods ($):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	416,902,176	467,886,678	496,268,700	521,611,200	559,271,513
15. Average payment per service, all payment methods ($):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	not available	not available	not available	not available	not available

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	2,571	3,037	2,892	2,714	2,928
17. Total number of claims, out-patient (#).	21,570	29,217	26,479	26,059	31,100
18. Total payments, in-patient ($).	8,655,520	12,152,757	11,427,627	12,918,117	16,290,426
19. Total payments, out-patient ($).	2,694,973	4,089,018	3,776,489	3,783,059	4,369,889
20. Average payment, in-patient ($).	3,366.60	4,001.57	3,951.50	4,759.81	5,563.67
21. Average payment, out-patient ($).	124.94	139.87	142.60	145.17	140.51
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	183,497	192,272	211,464	212,795	210,294
23. Total payments ($).	5,568,205	6,148,444	7,381,785	7,691,159	7,579,028
24. Average payment per service ($).	30.340	31.980	34.900	36.14	36.00

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	565	567	557	569	418
26. Total number of claims, out-patient (#).	6,053	6,335	6,676	6,025	6,069
27. Total payments, in-patient ($).	1,028,127	1,065,302	2,008,580	1,847,910	1,348,148
28. Total payments, out-patient ($).	905,479	2,435,560	3,267,764	914,251	1,216,073
29. Average payment, in-patient ($).	1,819.69	1,878.84	3,607.40	3,249.89	3,225.00
30. Average payment, out-patient ($).	149.59	384.46	489.00	151.73	200.00
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	7,116	6,763	6,345	5,826	5,324
32. Total payments ($).	520,712	500,757	529,029	607,066	519,782
33. Average payment per service ($).	73.17	74.04	83.40	104.20	98.00

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	105	101	not available	116	102
35. Number of services provided (#).	3,318	3,256	3,401	3,455	3,498
36. Total payments ($).	590,125	660,870	677,295	714,590	750,122
37. Average payment per service ($).	177.86	202.97	199.15	206.83	214.44

Endnotes

1. The population data is based on records of residents registered with Manitoba Health as of June 1.
2. Includes both chronic care and rehabilitative care.

Saskatchewan

Introduction

In 2003-2004, Saskatchewan Health continued to progress toward fulfilling the goals outlined in our Action Plan. Released in December 2001, *Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care* outlines our vision for the future of health care and provides a blueprint for the continued delivery of accessible, quality health care in Saskatchewan.

Saskatchewan Health continues to look ahead, to plan and to build a health care system that can provide access to quality services today and into the future. However, we recognize that there are a number of issues that need to be factored into our future plans including: sustainability, recruitment and retention of health care providers, access to services and changing demographics.

Saskatchewan Health plays a leadership role in health program and policy development for our province. This involves working in partnership with regional health authorities and key stakeholders including community organizations, professional associations, post-secondary educational institutions, unions, consumers and other provincial and federal government departments.

Our top priority is to improve the quality of health care and services, while ensuring our health system remains sustainable into the future. In 2003-2004, we progressed towards this goal with initiatives such as: the development and launch of *HealthLine*; our work with the regional health authorities and physicians' organizations to better manage surgical access by implementing the Surgical Patient Registry and Target Time Frames; new policies and initiatives to ensure diversity within the health care sector; negotiations to increase compensation for physicians and nurses; and many, many more.

In 2003-2004, the Saskatchewan government invested $2.527 billion in health care. This represents an increase of 7.9 percent or $184 million over the previous year. Health care continues to be a priority for the people of Saskatchewan. The government responded to this priority by increasing our health care investment to 42 percent of program spending in 2003-2004. The following list provides only a snapshot of some of the successes related to *The Action Plan for Saskatchewan Health Care* over the past year.

- *HealthLine* was introduced in August 2003. During its first eight months of implementation, registered nurses answered over 40,000 health care questions.
- In its first full year of operation, the Health Quality Council helped enhance the efficiency and accountability of the health care system and inform the public about the quality of health services in the province through:
  - developing its first strategic plan to improve evidence-based decision making in the sector;
  - developing and launching the Quality Improvement Network; and,
  - launching an Innovation Fund, which invested $170,000 to support new ideas in quality improvement.
- Surgical access was improved by developing and launching the Surgical Patient Registry and target time frames.
- 165 students received $700,000 in undergraduate nursing bursaries, and another nine bursaries were awarded to Registered Nurses studying to become primary care nurse practitioners.
- Several capital projects were launched and several were completed in 2003-2004: the Parkland Regional Care Centre in Melfort; the All Nations Healing Hospital in Fort Qu'Appelle; the Tatagwa View Long-term Care Facility in Weyburn; a jointly used facility in Ile-à-la Crosse; the maternal and newborn care

centre at the Regina General Hospital; and the new Cypress Hills Regional Hospital.

In 2003-2004, we continued to build a foundation for change, as outlined in *The Action Plan for Saskatchewan Health Care*. The first step was to reconfigure the 32 health districts into 12 regional health authorities in 2002-2003. In 2003-2004, regional health authorities worked with Saskatchewan Health to implement a better way of managing investment, linking dollars to results, and promoting quality and accountability.

In 2003-2004, the government invested almost $1.7 billion in the regional health authorities for hospital-based services, long-term and community care, primary health care, and other locally targeted health care services such as:

☐ about 800,000 days of in-patient hospital stays;
☐ about 72,000 Computed Tomography (CT) scans and 12,750 Magnetic Resonance Imaging (MRI) scans; and
☐ about 94,000 surgeries or about 258 per day.

In Canada, both the federal and provincial governments play a role in providing health care. The federal government provides funding to support health, education and social services through Canada Health and Social Transfer (CHST). It also provides health services to certain members of the population (e.g., veterans, military personnel and First Nations on reserve) and maintains safety for food and drugs in Canada. Provincial governments have responsibility for most other aspects of health care delivery. Saskatchewan Health sets policy and standards for health services and administers the Province's annual health budget of almost $2.6 billion.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and surgical-dental services in Saskatchewan. Section 6.1 of *The Department of Health Act* authorizes that the Minister of Health may:

☐ pay part of, or the whole of, the cost of providing health services for any persons or classes of person that may be designated by the Lieutenant Governor in Council;
☐ make grants or loans or provide subsidies to regional health authorities, health care organizations or municipalities for providing and operating health services or public health services;
☐ pay part of or the whole of the cost of providing health services in any health region or part of a health region in which those services are considered by the Minister to be required;
☐ make grants or provide subsidies to any health agency that the Minister considers necessary; and
☐ make grants or provide subsidies to stimulate and develop public health research and to conduct surveys and studies in the area of public health.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* provide the authority for the Minister of Health to establish and administer a plan of medical care insurance for residents. *The Regional Health Services Act* provides the authority to establish 12 regional health authorities, replacing the former 32 district health boards.

Sections 5 and 11 of *The Cancer Foundation Act* provide for establishing a Saskatchewan Cancer Agency and for the Agency to coordinate a program for diagnosing, preventing and treating cancer.

The mandates of the Department of Health, regional health authorities and the Saskatchewan Cancer Agency for 2003-2004 are outlined in *The Department of Health Act*, *The Regional Health Services Act* and *The Cancer Foundation Act*.

1.2 Reporting Relationship

The Department of Health is directly accountable to, and regularly reports to, the Minister of Health on the funding and administering funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual report concerning the medical care insurance plan to the Legislative Assembly.

The Regional Health Services Act prescribes that a regional health authority shall submit to the Minister of Health:

☐ a report on the activities of the regional health authority; and

☐ a detailed, audited set of financial statements.

Section 54 of *The Regional Health Services Act* requires that the regional health authority shall submit to the Minister any reports that the Minister may request from time to time. All regional health authorities are required to submit a financial and health service plan to Saskatchewan Health.

The Cancer Foundation Act prescribes that the Cancer Foundation shall, in each fiscal year, submit a report about its business and a financial statement to the Minister of Health for the fiscal year immediately preceding.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government departments and agencies, including Saskatchewan Health. It includes an audit of departmental payments to regional health authorities, the Saskatchewan Cancer Agency and to physicians and dental surgeons for insured physician and surgical-dental services. The Provincial Auditor may also conduct audits of regional health authority boards. The Provincial Auditor independently determines the scope and frequency of his or her audits based on accepted professional standards.

Section 57 of *The Regional Health Services Act* requires that an independent auditor, who possesses the prescribed qualification and is appointed for that purpose by the regional health authority, shall audit the accounts of a regional health authority at least once in every fiscal year. A detailed, audited set of financial statements must be submitted annually, by each regional health authority, to the Minister of Health.

Section 34 of *The Cancer Foundation Act* prescribes that the records and accounts of the Foundation shall be audited at least once a year by the Provincial Auditor or by a designated representative.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Regional Health Services Act was proclaimed on August 1, 2002, to replace *The Health Districts Act* as the authority to amalgamate the existing 32 health districts into 12 regional health authorities. Section 8 of *The Regional Health Services Act* gives the Minister the authority to provide funding to a regional health authority or a health care organization for the purpose of the Act.

Section 10 of *The Regional Health Services Act* permits the Minister to designate facilities including hospitals, special-care homes and health centres. Section 11 prescribes standards for delivering services in those facilities by regional health authorities and health care organizations that have entered into service agreements with a regional health authority.

The Act sets out new accountability requirements for regional health authorities and health care organizations. These requirements include submitting annual operational and financial and health service plans for Ministerial approval (sections 50-51), establishing community advisory networks (section 28) and reporting critical incidents (section 58). The Minister also has the authority to establish a provincial surgical registry to help manage surgical wait times (section 12). The Minister retains authority to inquire into matters (section 59), appoint a public administrator if necessary (section 60) and approve general and staff practitioner bylaws (sections 42-44).

Funding for hospitals is included in the funding provided to regional health authorities.

As of March 31, 2004, the following facilities were providing insured hospital services to both in- and out-patients:

☐ 66 acute care hospitals provided in- and out-patient services; and
☐ one rehabilitation hospital provided treatment, recovery and rehabilitation care for patients disabled by injury or illness. Rehabilitation services are also provided in a geriatric rehabilitation unit in one other hospital and in two special-care facilities.

The *Hospital Standards Act* and The Hospital Standards Regulations (1980) established minimum standards for care and certain administrative requirements for hospitals.

With the passage of *The Regional Health Services Act*, Saskatchewan plans to incorporate those provisions relating to hospital organization and program standards under the new Act; thereby, allowing for the repeal of *The Hospital Standards Act* and The Hospital Standards Regulations (1980).

A comprehensive range of insured services is provided by hospitals. These may include:

☐ public ward accommodation;
☐ necessary nursing services;
☐ the use of operating room and case room facilities;
☐ required medical and surgical materials and appliances;
☐ x-ray, laboratory, radiological and other diagnostic procedures;
☐ radiotherapy facilities;
☐ anaesthetic agents and the use of anaesthesia equipment;
☐ physiotherapeutic procedures;
☐ all drugs, biological and related preparations required for hospitalized patients; and
☐ services rendered by individuals who receive remuneration from the hospital.

The Action Plan for Saskatchewan Health Care establishes new hospital categories and outlines a standard array of services that should be available in each hospital. Hospitals are grouped into the following five categories: Community Hospitals, Northern Hospitals, District Hospitals, Regional Hospitals and Provincial Hospitals.

One of the elements of the Action Plan is to provide reliable, predicable hospital services, so people know what they can expect 24 hours a day, 365 days a year. While not all hospitals will offer the same kinds of services, reliability and predictability means:

☐ it is widely understood which services each hospital offers; and
☐ these services are always there when needed.

This service delivery framework will ensure quality, predictable hospital services and help guide decisions about where to invest new funds.

Regional health authorities have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs and available health professional funding resources.

The process for adding a hospital service to the list of services covered by the health care insurance plan involves a comprehensive review, considering such factors as service need, anticipated service volume, health outcomes by the proposed and alternative services, cost and human resource requirements, including availability of providers as well as initial and ongoing competency assurance demands. Depending on the specific service request, consultations could involve several branches within Saskatchewan Health as well as external stakeholder groups such as health regions, service providers and the public.

2.2 Insured Physician Services

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* enable the Minister of Health to establish and administer a plan of medical care insurance for provincial residents. Amendments were made in April and October 2003, to the

Physician Payment Schedule of The Saskatchewan Medical Care Insurance Payment Regulations (1994) in accordance with an agreement reached with the Saskatchewan Medical Association. Those amendments provided for the addition of new insured physician services, changes in payment levels for selected services, and definition or assessment rule revisions to existing selected services with significant monetary impact.

Physicians may provide insured services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra billing for insured services.

As of March 31, 2004, there were 1,662 physicians licensed to practice in the province and eligible to participate in the medical care insurance plan.

Physicians may opt out or not participate in the Medical Services Plan, but if doing so, must fully opt out of all insured physician services. The "opted out" physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to be reimbursed for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2004, there were no "opted out" physicians in Saskatchewan.

Insured physician services are those that are medically necessary, are covered by the Medical Services Plan of the Department of Health and are listed in the Physician Payment Schedule of The Saskatchewan Medical Care Insurance Payment Regulations (1994) of *The Saskatchewan Medical Care Insurance Act*.

There were approximately 3,000 different insured physician services as of March 31, 2004.

A process of formal discussion between the Medical Services Plan and the Saskatchewan Medical Association addresses new insured physician services and definition or assessment rule revisions to existing selected services (modernization) with significant monetary impact. The Executive Director of the Medical Services Branch manages this process. When the Medical Services Plan covers a new insured physician service or significant revisions occur to the Physician Payment Schedule, a regulatory amendment is made to the Physician Payment Schedule.

Although formal public consultations are not held, any member of the public may make recommendations about physician services to be added to the Plan.

2.3 Insured Surgical-Dental Services

Dentists registered with the College of Dental Surgeons of Saskatchewan and designated by the College as specialists able to perform dental surgery may provide insured surgical-dental services under the Medical Services Plan. As of March 31, 2004, 94 dental specialists were providing such services.

Amendments were made in April 2003, to The Saskatchewan Medical Insurance Branch Payment Schedule for Insured Services Provided by a Dentist. Those amendments provided for changes in payment levels for selected services.

Dentists may opt out or not participate in the Medical Services Plan, but if doing so, must opt out of all insured surgical-dental services. The dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

There were no "opted out" dentists in Saskatchewan as of March 31, 2004.

Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital. Such services include:

- ☐ oral surgery required in hospital as a result of trauma;

☐ treatment for infants with cleft palate;
☐ hospital-based dental care to support medical/surgical care (e.g., extractions when medically necessary); and
☐ surgical treatment for temporomandibular joint dysfunction.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with provincial dental surgeons. The Executive Director of the Medical Services Branch manages the process of adding a new service.

Although formal public consultations are not held, any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include:

☐ in-patient and out-patient hospital services provided for reasons other than medical necessity;
☐ the extra cost of private and semi-private hospital accommodation not ordered by a physician;
☐ physiotherapy and occupational therapy services not provided by or under contract with a regional health authority;
☐ services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health;
☐ non-emergency cataract and non-emergency diagnostic imaging services provided outside Saskatchewan without prior written approval;
☐ non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval;
☐ non-medically required elective physician services;
☐ surgical-dental services that are not medically necessary or are not required to be performed in a hospital; and
☐ services covered by the Saskatchewan Workers' Compensation Board.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with regional health authorities, physicians and dentists. There are no charges allowed in Saskatchewan for medically necessary hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary. Compliance is monitored through consultations with regional health authorities, physicians and dentists.

Insured hospital services could be de-insured by the government if they were determined to be no longer medically necessary. The process is based on discussions among regional health authorities, practitioners and officials from the Department of Health.

Insured surgical-dental services could be de-insured if they were determined to not be medically necessary or if they were not required to be carried out in a hospital. The process is based on discussion and consultation with the dental surgeons of the province and managed by the Executive Director of the Medical Services Branch.

Insured physician services could be de-insured if they were determined to not be medically required. The process is based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

No health services were de-insured in 2003-2004.

3.0 Universality

3.1 Eligibility

The Saskatchewan Medical Care Insurance Act (sections 2 and 12) and The Medical Care Insurance Beneficiary and Administration Regulations define eligibility for insured health services in Saskatchewan. Section 11 of the Act requires that all residents register for provincial health coverage. There were no changes to this legislation during 2003-2004.

Eligibility is limited to residents. A "resident" means a person who is legally entitled to remain in Canada, who makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor in Council to be a resident. Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month of establishing residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not eligible for insured health services in Saskatchewan:

- members of the Canadian Forces and the Royal Canadian Mounted Police (RCMP), federal inmates and refugee claimants;
- visitors to the province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the RCMP, if stationed in or resident in Saskatchewan on their discharge date;
- released federal inmates (this includes those prisoners who have completed their sentences in a federal penitentiary and those prisoners who have been granted parole and are living in the community); and
- refugee claimants, on receiving Convention Refugee status (immigration documentation is required).

3.2 Registration Requirements

The following process is used to issue a health services card and to document that a person is eligible for insured health services:

- every resident, other than a dependent child under 18 years, is required to register;
- registration should take place immediately following the establishment of residency in Saskatchewan;
- registration can be carried out either in person in Regina or by mail;
- each eligible registrant is issued a plastic health services card bearing the registrant's unique lifetime nine-digit health services number; and
- cards are renewed every three years. (Current cards expire in December 2005.)

All registrations are family-based. Parents and guardians can register dependent children in their family units if they are under 18 years of age. Children 18 and over living in the parental home or on their own must self-register.

The number of persons registered for health services in Saskatchewan on June 30, 2003, was 1,007,753.

3.3 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of a work permit, student permit or Minister's permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status combined with an employment/student permit, Minister's permit or permanent resident, that is, landed immigrant, record.

As of June 30, 2003, there were 4,622 such temporary residents registered with Saskatchewan Health.

4.0 Portability

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency. However, where one spouse arrives in advance of the other, the eligibility for the later arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the thirteenth month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences in Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents while temporarily absent within Canada. There were no changes to this legislation in 2003-2004.

Continued coverage during a period of temporary absence is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

☐ education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);

☐ employment of up to 12 months (no documentation required); and

☐ vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority for payment of in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province. Section 10 of The Saskatchewan Medical Care Insurance Payment Regulations (1994) provides payment for physician services to Saskatchewan beneficiaries temporarily residing outside the province.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are at the host province rates. The reciprocal arrangement for physician services applies to every province except Quebec. Payments/reimbursement to Quebec physicians, for services to Saskatchewan residents, are made at Saskatchewan rates (Saskatchewan Physician Payment Schedule). However, the physician fees will be paid at Quebec rates with prior approval. The out-of-province reciprocal hospital per diem billing rates have recently increased significantly.

In 2003-2004, expenditures for insured physician services in other provinces were $19.48 million. Insured hospital services in other provinces were $36.93 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Saskatchewan Medical Care Insurance Act* describes the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers and vacationers and travelers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on the expiration of the approved period as follows:

☐ education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);

☐ employment of up to 24 months (written confirmation from the employer is required); and

☐ vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day.

In 2003-2004, $728,400 was paid for in-patient hospital services and $373,300 was spent on out-patient hospital services outside Canada. In 2003-2004, expenditures for insured physician services outside Canada were $583,200.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered.

Prior approval is required for the following services provided out-of-province:

☐ alcohol and drug, mental health and problem gambling services; and

☐ cataract surgery services, bone densitometry (outside of hospitals) and non-urgent Magnetic Resonance Imaging (MRI), because Saskatchewan Health does not normally cover these services out-of-province.

Before the Department of Health funds non-urgent services for a Saskatchewan resident in another province or territory, prior approval from the Department must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada:

☐ If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring specialist must seek prior approval from the Medical Services Plan of Saskatchewan Health. Requests for out-of-country cancer treatment must be approved by the Saskatchewan Cancer Agency. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

☐ Saskatchewan Health does not normally cover elective (non-emergency) hospital, physician, optometric and chiropractic services; therefore, prior approval is required.

5.0 Accessibility

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in providing public services, which include insured health services on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2004, Saskatchewan had 3,015 staffed hospital beds in 66 acute care hospitals, including 2,446 acute care beds, 236 psychiatric beds and 333 other beds. The Wascana Rehabilitation Centre had 43 rehabilitation beds and 205 extended care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

Keeping and attracting key health providers, such as nurses, to provide insured hospital services continues to be a top priority for Saskatchewan Health. Tracking the actual number of people who work in the health professions can be difficult because people move and change jobs, hours of work or even careers.

One way to measure our health care workforce is to count how many providers are registered in the province. The professional regulatory bodies in Saskatchewan do this every year. Much of this information is reported to the Canadian Institute for Health Information (CIHI), allowing comparisons with other provinces.

According to the three professional regulatory bodies for nursing in Saskatchewan, in 2003 there were 12,063 nurses in Saskatchewan, an overall increase from the 11,940 nurses reported in 2002. The number of nurses and ratio of nurses to the provincial population has stabilized over the past five years. This is a positive trend. Other trends such as the aging of the nursing workforce indicate we need to continue efforts at retaining and recruiting nurses.

There are signs of progress that show nursing graduates are more enthusiastic about remaining in Saskatchewan. Over the past couple of years, our province has retained about 80 percent of graduates from our nursing education program.

The number of Registered Nurses (RN) per capita in Saskatchewan in 2002 (81.8 per 10,000 population) is higher than the Canadian average (73.4 per 10,000 population). This also represents a slight decrease from 1998 for Saskatchewan (82.4). There is also considerable variation in RN per population ratios across Canada, from a low of 65 per 10,000 in Ontario to a high of 117.6 in the Northwest Territories.

Listed below are some of the 2003-2004 initiatives implemented to improve the retention and recruitment of health care providers:

☐ A nursing bursary program of $500,000 provided to students training to be future Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses was continued. The Province introduced Primary Care Nurse Practitioner bursaries for individuals studying to become nurse practitioners in Saskatchewan.

☐ A northern nursing program with 40 seats for Aboriginal students delivered through the First Nations University of Canada was continued.

☐ Access to the Nursing Education Program of Saskatchewan (NEPS) has been enhanced through distance delivery. The entire first year of the program is available by distance learning. The development of a Bachelor of Science in Nursing second-degree program will begin in 2005-2006.

☐ Over the past three years, $960,000 has been provided for projects related to quality workplaces, nursing workforce casualization and the retention of nursing graduates. The Quality Workplace Program pilot projects were evaluated and new sites in other locations in the province were added to the program.

☐ Saskatchewan Health provided professional development funding to the regional health authorities to support the orientation and workload relief for nurse preceptors and also made conflict resolution workshops available to all regional health authority staff.

☐ Saskatchewan Health provided funding to regional health authorities to support Aboriginal Awareness training in the health care system.

☐ Saskatchewan Health initiated a supply-demand study of medical diagnostic disciplines. Results of the study will be available in fall 2004 and will be used to determine future need.

☐ A new four-seat cytology program at the Saskatchewan Institute of Applied Science and Technology (SIAST) started in fall 2003.

☐ Nuclear Medicine graduates from a program purchased from the Southern Alberta Institute of Technology (SAIT), Calgary, entered the labour force for the first time. SAIT continues to accept four Saskatchewan students annually.

- ☐ SAIT has also entered into a contract with the Province of Saskatchewan to train respiratory therapy students for the Saskatchewan market. Eight students are accepted annually. The first graduates will be available to work in Saskatchewan in 2004-2005.
- ☐ The 2003 Health Human Resource Report on the health providers working in Saskatchewan's regional health authorities was produced.
- ☐ Saskatchewan Health provided funding to explore the challenges and opportunities for entry-level staff to achieve job satisfaction and career advancement through career laddering. This project is ongoing.
- ☐ Provincial health human resource planning guidelines were developed and serve as a foundation for building future strategies and initiatives. Human resource performance expectations and indicators were developed and will form the basis of accountability frameworks between major third parties and the Province.
- ☐ Saskatchewan Health worked with Saskatchewan Government Relations and Aboriginal Affairs and a variety of nursing partners to expand the Saskatchewan Immigrant Nominee Program to include the nursing professions.

Aside from nurses and physicians, there is a wide range of other health care professionals who are also vital to the provision of quality care. Registration data for these professionals – including technologists, therapists and pharmacists – indicates that the number of these professionals working in Saskatchewan has for the most part increased over the past decade.

Regarding the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services, Saskatchewan Health notes the following.

- ☐ MRI machines are located in Saskatoon (2) and Regina (1). Regina Qu'Appelle Regional Health Authority has received approval and is in the process of acquiring a second MRI. It is planned to be operating in 2005-2006.
- ☐ CT scanners are available in Saskatoon (3), Regina (3), Prince Albert (1) and Swift Current/Moose Jaw (1). In 2003-2004, three additional CT scanners were purchased for the following regional health authorities: one each for Five Hills (Moose Jaw), Cypress (Swift Current) and Sunrise (Yorkton). These machines will be operating in 2004-2005. The portable scanner that was shared between Swift Current and Moose Jaw was traded in.
- ☐ Renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton, Swift Current and North Battleford. Another satellite unit will begin operating in 2004-2005 in Moose Jaw.
- ☐ Cancer treatment services are provided by the Saskatchewan Cancer Agency's two cancer clinics, the Saskatoon Cancer Centre and the Allan Blair Cancer Centre in Regina. In 2003-2004, approximately 4,700 new patients began treatment for cancer. Both centres provided approximately 35,000 radiation therapy treatments and 14,000 chemotherapy treatments to cancer patients in Saskatoon and Regina.
- ☐ Twenty-one sites are involved in the Community Oncology Program of Saskatchewan (COPS) that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon. In 2003, over 800 patients made approximately 6,000 visits to COPS centres.
- ☐ Approximately 73 percent of surgery services are provided in Saskatoon and Regina, where there are specialized physicians and staff and the equipment to perform a full range of surgical services. An additional 22 percent is provided in six mid-sized hospitals in Prince Albert, Moose Jaw, Yorkton, Swift Current, North Battleford and Lloydminster. , with the remaining surgery performed in smaller hospitals across the province.

- Telehealth Saskatchewan links continue to provide residents in a number of rural and remote areas with access to specialist, family physician and other health provider services without having to travel long distances.

A number of measures were taken in 2003-2004 to improve access to insured hospital services.

- Access and use of specialized medical imaging services, including MRI, CT and bone mineral density testing has grown steadily in Saskatchewan. In 2003-2004, approximately 13,000 MRI tests and 82,000 CT tests were performed.
- Access to renal dialysis services continues to improve, with the opening in fall 2003 of the dialysis satellite at the Battlefords Union Hospital.
- The Northern Telehealth Network (NTN) has proven to be an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health continues to support the network and was successful in August 2001, in securing funding (approximately $1 million) from Health Canada under the Canadian Health Infostructure Partnership Program (CHIPP) for further development of the Telehealth Saskatchewan program. As of March 31, 2004, the Telehealth Saskatchewan network has been established at 17 sites in 15 communities.
- The Chronic Renal Insufficiency Clinics that were established in the Regina and Saskatoon regions in summer 2001 continue to grow. The goals of these clinics are to delay the need for dialysis and to better prepare patients in making their treatment choices: haemodialysis, peritoneal or home dialysis or transplant.
- The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven sites around the province and one mobile mammography unit that travels into communities not served by a stationary site. The Screening Program provides mammograms to between 34,000 and 37,000 women annually.
- The Cancer Agency began implementing the Prevention Program for Cervical Cancer in 2003. This program consists of the following components:
    - a comprehensive information system;
    - recruitment and recall strategies;
    - results notification;
    - quality patient/client management; and
    - quality assurance processes.
- The Provincial Malignant Hematology/Stem Cell Transplant Program continues to grow. In 2003-2004, 49 patients with aggressive or advanced blood or other system cancers received stem cell or bone marrow transplants. The program also became part of the hematology clinic rotation for residents of Internal Medicine at the University of Saskatchewan.

Capital equipment purchases by regional health authorities is consistent with the criteria established under the February 2003 Health Accord. Regional health authority acquisitions are reviewed to ensure consistency with provincial health strategies and priorities and Health Accord principles. Capital equipment acquisitions in 2003-2004 supported enhanced access to diagnostic imaging and surgical services.

Saskatchewan Health continues to place priority on promoting surgical access and improving the province's surgical system. Saskatchewan Health, with advice from the Saskatchewan Surgical Care Network (SSCN) is leading several initiatives designed to improve the management of wait times.

One such initiative is the Surgical Patient Registry. Information from this comprehensive database allows the surgical care system to better predict who will require what type of surgery in what time frames. The Registry will improve waitlist management, help determine system capacity and resource requirements, and reduce wait times for patients. The Surgical Patient Registry operates in the following regional health authorities: Five Hills (Moose Jaw), Sunrise (Yorkton), Prince Albert Parkland, Prairie North

(North Battleford/Lloydminster), Cypress (Swift Current), Regina Qu'Appelle and Saskatoon.

Saskatchewan Health continues to participate in the Western Canada Waiting List (WCWL) Project, along with partner organizations from the four western provinces. The project works closely with physicians, the public, regional health authorities and governments to develop and test clinical assessment tools.

The SSCN has formed a joint Research and Evaluation Working Group with the Western Canada Waiting List project to formally evaluate the Patient Assessment Tools/Process. The Working Group will review the reliability and validity of the tools in the context of the overall process that combines the assessment score from the tools with the urgency profiles of the specific procedure. The Patient Assessment Process will help increase consistency and fairness by standardizing the factors physicians use to assess their patients' level of need for surgery. This will help to ensure those with the greatest need for surgeries receive it first.

In March 2004, the Minister of Health announced Target Time Frames for Surgery. These Targets are "performance goals" for the surgical care system and will allow the surgical care system to better monitor and track patients and help ensure they receive care according to their level of need.

In January 2003, the Saskatchewan surgical Web site was launched **www.sasksurgery.ca**. It allows patients to obtain information on how long they may expect to wait for their particular procedure. Saskatchewan Health is currently redesigning the Web site to improve the ability of the site to capture and present the surgical care system data produced by the Surgical Patient Registry. It is anticipated that a revised Web site launch will occur in fall 2004.

5.3 Access to Insured Physician and Surgical-Dental Services

As of March 31, 2004, there were 1,662 physicians licensed to practice in the province and eligible to participate in the Medical Care Insurance Plan. Of these, 946 (56.9 percent) were family practitioners and 716 (43.1 percent) were specialists. This shift to more specialists in the last two years is the result of provincial review and certification of foreign-trained specialists and their inclusion in the category previously occupied by only Canadian certified specialists.

As of March 31, 2004, there were approximately 375 practising dentists and dental surgeons located in all major centres in Saskatchewan. Ninety-four provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2003-2004 to enhance access to insured physician services and reduce waiting times.

☐ A Specialist Physician Enhancement Training Program provides grants of up to $80,000 per year to allow practising specialists the opportunity to obtain additional training and requires a return service commitment.

☐ A pilot Regional Practice Establishment Program provides grants of $10,000 to eligible family physicians who establish a practice in a regional centre for a minimum of 18 months.

☐ A Long-term Service Retention Program rewards physicians who work in the province for 10 or more years.

☐ A Specialist Emergency Coverage Program compensates specialist physicians who make themselves available to provide emergency coverage to acute care facilities.

☐ A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.

☐ The Specialist Recruitment and Retention Fund Program provides bursaries to eligible residents in specialty training for a maximum of three years funding in return for a service commitment.

☐ A Physician Recruitment Coordinator is assisting regional health authorities and physicians in the recruitment process.

☐ Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program, which compensates physicians providing emergency room coverage in rural areas and helps those communities with fewer than three physicians to gain access to other physicians to provide weekend relief.

- The Rural Practice Establishment Grant Programs make grants of $18,000 to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.
- The Medical Resident Bursary Program provides bursaries of $25,000 to family medicine residents to help them with medical educational expenses in return for a rural service commitment.
- The Undergraduate Medical Student Bursary Program provides an annual grant of $15,000 to medical students who sign a return service commitment to a rural community.
- The Rural Practice Enhancement Training Program provides income replacement to practising rural physicians and assistance to medical residents wishing to take specialized training in an area of need in rural Saskatchewan. A return service commitment is required.
- The Rural Emergency Care Continuing Medical Education Program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are required to provide service in rural Saskatchewan after completing an educational program.
- The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program while they take vacation, education or other leave.
- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services through the Alternate Payments and Primary Health Services Program.
- The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to help stabilize the supply of physicians in northern Saskatchewan.
- The Rural Extended Leave Program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks.
- The Rural Travel Assistance Program provides travel assistance to rural physicians participating in educational activities.
- The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by Section 48 of *The Saskatchewan Medical Care Insurance Act* as follows:

- a Medical Compensation Review Committee is established within 15 days of either the Saskatchewan Medical Association or the government providing notice to begin discussing a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare an agreement respecting insured services that is satisfactory to both parties;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board, consisting of an appointee by either party who in turn select a third member; and
- the Board has the authority to make a decision binding on the parties.

In June 2003, a new three-year agreement (retroactive to April 1, 2003) was successfully negotiated with the Saskatchewan Medical Association. It provides an increase in the Physician Payment Schedule of 8.3 percent effective October 1, 2003, and 6 percent on

April 1, 2004 and 2005. Similar increases were applied to non fee-for-service physicians. Additional improvements include a total of $11.2 million to bolster recruitment and retention programs and $3 million per year for new items and modernization of the Payment Schedule.

Section 6 of The Saskatchewan Medical Care Insurance Payment Regulations, 1994, outlines the obligation of the Minister of Health to make payment for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salaries, capitation arrangements and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services. Total expenditures for in-province physician services and programs in 2003-2004 amounted to $465.5 million - $303.3 million for fee-for-service billings, $20.4 million for Emergency Coverage Programs, $125.4 million in non-fee-for-service expenditures, and $16.3 million for Saskatchewan Medical Association programs as outlined in the agreement.

5.5 Payments to Hospitals

In 2003-2004, funding to regional health authorities was based on historical funding levels adjusted for inflation, collective agreement costs and utilization increases. Each regional health authority is given a global budget and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes.

Regional health authorities may receive additional funds for providing specialized hospital programs (e.g., renal dialysis, specialized medical imaging services, specialized respiratory services) or for providing services to residents from other health regions.

Payments to regional health authorities for delivering services are made pursuant to section 8 of *The Regional Health Services Act*. The legislation provides the authority for the Minister of Health to make grants to regional health authorities and health care organizations for the purposes of the Act and to arrange for providing services in any area of Saskatchewan if it is in the public interest to do so.

Regional health authorities provide an annual report on the aggregate financial results of their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in the Department of Health 2003-2004 Annual Report, the 2003-2004 Annual Budget and related budget documents, its 2003-2004 Public Accounts, and the Quarterly and Mid-Year Financial Reports. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents.

Federal contributions have also been acknowledged on the Saskatchewan Health Web site, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums. Federal assistance was also recognized in The Action Plan progress reports released in both spring and fall 2002.

7.0 Extended Health Care Services

As of March 31, 2003, the range of extended health care services provided by the provincial government included long-term residential care services for Saskatchewan residents, certain community-based health services such as home care, as well as a wide range of other health, social support, mental health, addiction treatment and drug benefit programs.

Nursing Home Intermediate Care Services

☐ Special-care homes provide institutional long-term care services to meet the needs of individuals, primarily with heavy care needs. Services offered include care and accommodation, respite care, day programs, night care, palliative care and, in some instances, convalescent care. These facilities are publicly funded through regional health authorities and are governed by *The Housing and Special-care Homes Act* and regulations.

☐ Public Health Services of regional health authorities provide immunization for residents in long-term care facilities and other similar residential facilities under the provincial immunization program. Saskatchewan Health purchases the vaccines and provides them free of charge to Public Health Services. This applies to influenza and pneumococcal vaccines.

Home Care Services

☐ The Home Care Program provides an option for people with varying degrees of short and long-term illness or disabilities to remain in their own homes rather than in a care facility. The Program is designed to provide care and services for individuals with palliative, acute and supportive care needs. Services include assessment and care coordination, nursing, personal care, respite care, homemaking, meals, home maintenance, therapy and volunteer services. Individualized funding is an option of the Home Care Program and provides funding directly to people so they can arrange and manage their own supportive services. The Home Care Program is governed by *The Regional Health Services Act.*

Ambulatory Health Care Services

☐ Saskatchewan regional health authorities provide a full range of mental health and alcohol and drug services in the community. Mental health services are governed by *The Mental Health Services Act.*

☐ Regional health authorities offer podiatry services. Services include assessment, consultation and treatment. The Chiropody Services Regulation of *The Department of Health Act* provides chiropodists and podiatrists with the ability to self-regulate their profession.

☐ Regina/Qu'Appelle and Saskatoon regional health authorities provide a Hearing Aid Program. Services include hearing testing, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids. *The Hearing Aid Act* and Regulations and *The Regional Health Services Act* govern these programs.

☐ Rehabilitation therapies, including occupational and physical therapies and speech and language pathology, are offered by the regional health authorities and help individuals of all ages improve their functional independence. Services are provided in hospitals, rehabilitation centres, long-term care facilities, community health centres, schools and private homes and include assessment, consultation and treatment. *The Regional Health Services Act* and The Community Therapy Regulations, which are under the authority of *The Department of Health Act*, govern these programs.

Adult Residential Care Services

Mental Health Services

☐ Apartment Living Programs and Group Homes provide a continuum of support and living assistance to individuals with long-term mental illnesses. These programs are governed by *The Residential Services Act.*

☐ Saskatchewan Health, in partnership with the Heartland Regional Health Authority, offers a rehabilitation program for people and families struggling with eating disorders. BridgePoint Centre delivers this program and is currently governed by *The Non-profit Corporations Act* (1995) and *The Co-operatives Act* (1996).

Alcohol and Drug Services

- ☐ The provision of Alcohol and Drug services generally falls under *The Regional Health Services Act*. Facilities that provide residential alcohol and drug services are licensed as listed below. Saskatchewan Health or the regional health authorities contract with community-based and non-profit organizations governed by *The Non-profit Corporations Act* to provide services.
- ☐ Detoxification services provide a safe and supportive environment in which the client is able to undergo the process of alcohol and/or other drug withdrawal and stabilization. Accommodation, meals and self-help groups are offered for up to 10 days. The Adult and Youth Group Homes Regulations of *The Housing and Special-care Homes Act* govern licensure of detoxification services.
- ☐ In-patient services are provided to individuals requiring intensive rehabilitative programming for their own or others' use of alcohol or drugs. Services offered include assessments, counselling, education and support for up to four weeks or longer depending on individual needs. The Adult and Youth Group Homes Regulations of *The Housing and Special-care Homes Act* govern licensure for in-patient services.
- ☐ Long-term residential services provide maintenance and transition programs for an extended period to individuals recovering from chemical dependency and addiction. These facilities offer counselling, education and relapse prevention in a safe and supportive environment. The Adult and Youth Group Homes Regulations of *The Housing and Special-care Homes Act* govern licensure for long-term residential services.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#)	1,041,256	1,021,762	1,024,788	1,024,827	1,007,753

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#):					
a. acute care	71	68	66	65	66
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. other	0	0	0	0	0
e. total	72	69	67	66	67
3. Payments ($):					
a. acute care	619,538,151 [1]	680,326,248 [1]	720,174,393 [1]	not available	811,561,671 [2]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	36,824,546	38,249,010	39,656,3[illegible]4	not available	not available [3]
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	656,362,697	718,575,258	759,830,777	not available	811,561,671
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	940	1,016	937	936	946
b. specialists	610	593	696	700	716
c. other	0	0	0	0	0
d. total	1,550	1,609	1,633	1,636	1,662
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	6,785,673	6,873,539	6,760,156	6,631,582	6,719,074
b. specialists	3,163,046	3,250,953	3,700,801	3,637,879	3,688,232
c. other	0	0	0	0	0
d. total	9,948,719	10,124,492	10,460,957	10,269,461	10,407,306
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	133,042,948	134,989,267	137,541,402	139,410,263	147,068,263
b. specialists	125,735,201	129,470,569	144,566,069	151,061,558	157,468,972
c. other	0	0	0	0	0
d. total	258,778,149	264,459,836	282,107,471	290,471,821	304,537,235
12. Average payment per fee for service service ($):					
a. general practitioners	19.61	19.64	20.35	21.02	21.89
b. specialists	39.75	39.83	39.06	41.52	42.69
c. other	0.00	0.00	0.00	0.00	0.00
d. all services	26.01	26.12	26.97	28.29	29.26
13. Number of services provided through all payment methods (#): [4]					
a. medical	6,028,070 [5]	6,071,567 [5]	6,017,477 [5]	5,788,055 [5]	5,841,196 [5]
b. surgical	723,626 [6]	787,655 [6]	994,321 [6]	984,405 [6]	998,297 [6]
c. diagnostic	2,312,606 [7]	2,288,038 [7]	2,262,256 [7]	2,179,286 [7]	2,174,220 [7]
d. other	884,417 [8]	977,232 [8]	1,186,903 [8]	1,317,715 [8]	1,393,593 [8]
e. total	9,948,719	10,124,492	10,460,957	10,269,461	10,407,306
14. Total payments to physicians paid through all payment methods ($): [4]					
a. medical	148,848,496 [5]	151,152,270 [5]	160,742,594 [5]	162,032,557 [5]	170,595,840 [5]
b. surgical	50,843,890 [6]	51,681,286 [6]	56,027,014 [6]	58,596,690 [6]	60,515,275 [6]
c. diagnostic	41,503,336 [7]	43,216,810 [7]	44,488,404 [7]	48,355,683 [7]	51,280,830 [7]
d. other	17,582,427 [8]	18,409,471 [8]	20,849,458 [8]	21,486,890 [8]	22,145,286 [8]
e. total	258,778,149	264,459,837	282,107,470	290,471,821	304,537,231
15. Average payment per service, all payment methods ($): [4]					
a. medical	24.69 [5]	24.90 [5]	26.71 [5]	27.99 [5]	29.21 [5]
b. surgical	70.26 [6]	65.61 [6]	56.35 [6]	59.52 [6]	60.62 [6]
c. diagnostic	17.95 [7]	18.89 [7]	19.67 [7]	22.19 [7]	23.59 [7]
d. other	19.88 [8]	18.84 [8]	17.57 [8]	16.31 [8]	15.89 [8]
e. all services	26.01	26.12	26.97	28.29	29.26

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	4,917	4,527	4,692	4,422	4,561
17. Total number of claims, out-patient (#).	43,296	46,199	45,320	50,401	45,510
18. Total payments, in-patient ($).	21,235,200	20,208,100	22,037,200	23,447,100	30,528,100
19. Total payments, out-patient ($).	5,622,500	6,046,600	5,836,500	7,144,800	6,405,900
20. Average payment, in-patient ($).	4,318.73	4,463.91	4,696.76	5,302.37	6,693.29
21. Average payment, out-patient ($).	129.86	130.88	128.78	141.76	140.76
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	392,400	425,800	444,430	458,100	509,784
23. Total payments ($).	12,237,200	13,767,600	15,520,000	16,948,900	19,477,300
24. Average payment per service ($).	31.19	32.33	34.92	37.00	38.21

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	380	272	252	287	231
26. Total number of claims, out-patient (#).	1,553	1,369	1,172	1,049	875
27. Total payments, in-patient ($).	1,891,000	1,039,500	1,009,400	1,891,800	728,400
28. Total payments, out-patient ($).	481,600	377,600	375,900	359,400	373,300
29. Average payment, in-patient ($).	4,976.32	3,821.69	4,005.56	6,591.64	3,153.25
30. Average payment, out-patient ($).	310.11	275.82	320.73	342.61	426.63
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	not available	not available	not available	not available	not available
32. Total payments ($).	1,186,900	722,400	588,100	1,129,300	583,200
33. Average payment per service ($).	not available	not available	not available	not available	not available

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	97	92	94	94	94
35. Number of services provided (#).	18,100	19,900	18,900	18,500	18,300
36. Total payments ($).	1,309,000	1,404,700	1,275,400	1,264,200	1,345,900
37. Average payment per service ($).	72.32	70.59	67.48	68.34	73.55

Endnotes

1. Based on provincial government funding summaries provided to the former health districts.
2. "This number includes estimated government funding to Regional Health Authorities (RHAs)(based on total projected expenditures less non-government revenue), as provided to Saskatchewan Health through the RHA annual operational plans. Acute care funding includes: acute care services , specialized hospital services, and in-hospital specialist services. Does not include inpatient rehabilitative care, inpatient mental health, or addiction treatment services. Does not include payments to Saskatchewan Cancer Agency for outpatient chemotherapy and radiation ."
3. Comparable annual information is not available at this time.
4. Fee-for-service only.
5. Includes visits, hospital care, psychotherapy.
6. Includes surgeries, surgical assistance, obstetrics, anaesthesia.
7. Includes x-rays, laboratory services, diagnostics.
8. Includes surcharges, premiums, on-call physician services.

Alberta

Introduction: Alberta's Health Care System

Alberta provides medically necessary, insured services in a public system that follows the principles of the *Canada Health Act*: public administration, comprehensiveness, universality, portability and accessibility. Medically necessary services include hospital and physician services and specific kinds of services provided by oral surgeons and other dental professionals.

Alberta also provides full and partial coverage for health care services not required by the *Canada Health Act*. They include:

- ☐ home care and long-term care;
- ☐ mental health services;
- ☐ dental and eyeglass benefits for recipients of the Alberta Widow's pension and their eligible dependents;
- ☐ palliative care;
- ☐ immunization programs for children;
- ☐ allied health services such as optometry (for residents under 19 and over 64 years), chiropractic and podiatry services;
- ☐ drug benefits through Alberta Blue Cross; and
- ☐ Alberta Aids to Daily Living.

Health System Governance

Alberta's health care system is defined in legislation and is governed by the Minister of Health and Wellness. The *Regional Health Authorities Act* makes regional health authorities responsible to the Minister for ensuring the provision of acute care hospital services, community and long-term care services, public health protection and promotion services and other related services. The *Alberta Cancer Board Act* makes the Alberta Cancer Board responsible to the Minister for providing cancer care, education and research. The Alberta Mental Health Board advises the Minister on strategic and policy matters related to mental health programs and services. Alberta's health legislation can be accessed at **http://www.health.gov.ab.ca/about/minister/legislation.html**.

Significant Events in 2003/2004

Effective on April 1, 2003, responsibility and funding for mental health services was transferred from the Alberta Mental Health Board to regional health authorities. Regional health authority boundaries were changed, reducing them from 17 to nine. HealthLink Alberta, a telephone information service, was launched. The service provides information and advice to Albertans. An eight-year, tri-lateral agreement was reached among Alberta Health and Wellness, the Alberta Medical Association and regional health authorities. The agreement provides new incentives and compensation arrangements for innovative programs in the area of primary care, physician on-call services and the automation of medical practice. More significant events are described in detail in the 2003-2004 Annual Report of the Alberta Ministry of Health and Wellness at **http://www.health.gov.ab.ca/resources/publications/AR03_04/index.html**.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Alberta Health Care Insurance Plan is publicly administered in accordance with The *Canada Health Act*. Since 1969, the *Alberta Health Care Insurance Act* has governed the operation of the Alberta Health Care Insurance Plan. Alberta

Health and Wellness administers the plan on a non-profit basis.

Alberta Health and Wellness registers eligible Alberta residents for coverage under the plan and compensates practitioners for insured services provided in accordance with negotiated agreements, the Schedule of Medical Benefits and the Schedule of Oral and Maxillofacial Surgery Benefits. Alberta Health and Wellness also provides funding to regional health authorities and provincial boards for the provision of insured hospital services.

1.2 Reporting Relationship

The Alberta Health Care Insurance Plan is fully accountable to the Minister of Health and Wellness and is managed by the Minister's departmental staff.

Each year the Ministry issues an annual report that documents key activities of the health care system including the Alberta Health Care Insurance Plan. The Annual Report provides consolidated financial statements for the previous fiscal year. The annual report also provides information about key achievements and results in a response to key performance measures and targets included in the previous year's business plan. The 2003-2004 Annual Report of the Alberta Ministry of Health and Wellness can be accessed at **http://www.health.gov.ab.ca/resources/publications/AR03_04/index.html**. The Ministry also issues an annual Statistical Supplement on data related to the Alberta Health Care Insurance Plan. The Statistical Supplement is accessible at **http://www.health.gov.ab.ca/resources/publications/pdf/AHCIPStatSupR03.pdf**.

1.3 Audit of Accounts

The Auditor General of Alberta audits the records and financial statements of the Ministry of Health and Wellness.

2.0 Comprehensiveness

2.1 Insured Hospital Services

In Alberta, except for cancer hospitals, regional health authorities are responsible to the Minister for ensuring the provision of insured hospital services. The *Hospitals Act*, the Hospitalization Benefits Regulation (AR244/90), the *Health Care Protection Act* and the Health Care Protection Regulation define how insured services are provided by hospitals or designated surgical facilities. According to the legislation, the Minister must approve all hospitals and surgical facilities.

The services provided by approved hospitals in Alberta range from the most advanced levels of diagnostic and treatment services for in-patients and out-patients to the routine care and management of patients with previously diagnosed chronic conditions. The benefits available to hospital patients in Alberta are defined in the Hospitalization Benefits Regulation (AR244/90).

The *Health Care Protection Act* in Alberta governs the provision of surgical services through non-hospital surgical facilities. Ministerial approval of a contract between the facility operator and a regional health authority is required for providing insured services. Ministerial designation of a non-hospital surgical facility and accreditation by the College of Physicians and Surgeons of Alberta are also required. According to the College, there are currently 53 non-hospital surgical facilities with accreditation status.

According to the *Health Care Protection Act*, Ministerial approval for a contractual agreement shall not be given unless:

- ☐ the insured surgical services are consistent with the principles of the *Canada Health Act*;
- ☐ there is a current and likely future need for the services in the geographical area;
- ☐ the proposed surgical services will not have a negative impact on the province's public health system;
- ☐ there will be an expected benefit to the public;

- ☐ the regional health authority has an acceptable business plan to pay for the services;
- ☐ the proposed agreement contains performance expectations and measures; and
- ☐ the physicians providing the services will comply with the conflict of interest and ethical requirements of the Medical Profession Act and bylaws.

2.2 Insured Physician Services

Insured physician services are paid for under the Alberta Health Care Insurance Plan. Only physicians and dentists who meet the requirements stated in the Alberta Health Care Insurance Act are allowed to provide insured services under the Albert Health Care Insurance Plan. In addition to insured services, a number of other practitioner services are covered under the Alberta Health Care Insurance Plan. They include opticians, podiatrists, denturists, optometrists, chiropractors, oral surgeons and dentists.

Before being registered with the Alberta Health Care Insurance Plan, a practitioner must complete the appropriate registration forms and include a copy of his or her license issued by the appropriate governing body or association, such as the College of Physicians and Surgeons of Alberta or the Alberta Dental Association and College.

Under section 8 of the Alberta Health Care Insurance Act, physicians and dentists may opt out of the Alberta Health Care Insurance Plan. As of March 31, 2004, there were no opted-out medical practitioners in the province.

The Medical Benefits Regulation defines which medical services are insured. These services are documented in the Schedule of Medical Benefits, which can be accessed at **http://www.health.gov.ab.ca/professionals/SOMB/Procedure_List.pdf**.

2.3 Insured Surgical-Dental Services

Alberta insures a number of medically necessary oral surgical and dental procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits available at **http://www.health.gov.ab.ca/professionals/allied/Dental_Procedure.pdf**. A dentist may perform a small number of these procedures, but the majority of the procedures can be billed to the Alberta Health Care Insurance Plan only when performed by an oral or maxillofacial surgeon.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Section 21 of the Alberta Health Care Insurance Regulation defines what services are not considered to be insured services. Section 4(1) of the Hospitalization Benefits Regulation provides a list of uninsured hospital services.

The Minister of Health and Wellness determines what services are covered by the Alberta Health Care Insurance Plan. Alberta Health and Wellness reviews scientific literature, consults with expert advisors and assesses policy, funding and training when considering which medical products, services or devices will be covered under the Alberta Health Care Insurance Plan. Insured physician services and any changes to the Schedule of Medical Benefits are negotiated among Alberta Health and Wellness, the Alberta Medical Association (AMA) and the regional health authorities. All changes to the Schedule of Medical Benefits require ministerial approval.

3.0 Universality

3.1 Eligibility

Under the terms of the Alberta Health Care Insurance Act, all Alberta residents are eligible to receive publicly funded health care services under the Alberta Health Care Insurance Plan. A resident is defined as a person lawfully entitled to be or to remain in Canada who makes the province his or her home and is ordinarily present in Alberta. The term "resident" does not include a tourist, transient or visitor to Alberta.

Persons moving permanently to Alberta from outside Canada are eligible for coverage if they are landed immigrants, returning landed immigrants or returning Canadian citizens. Temporary residents may also be eligible for coverage, if they intend to remain in Alberta for 12 months and their Canada entry documents are in order.

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan include:

☐ members of the Canadian Forces;
☐ members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank; and
☐ persons serving a term in a federal penitentiary.

3.2 Registration Requirements

All new Alberta residents are required to register themselves and their eligible dependents with the Alberta Health Care Insurance Plan. New residents in Alberta should apply for coverage within three months of arrival. Family members are registered on the same account for premium billing purposes. As of March 31, 2004, there were 3,165,157 Alberta residents registered with the Alberta Health Care Insurance Plan.

3.3 Other Categories of Individual

Temporary residents arriving from outside Canada who may be deemed residents include persons on Visitor Records, Student or Employment Authorization and Minister's Permits. There were 18,860 people covered under these conditions as of March 31, 2004.

3.4 Premiums

All Alberta residents, except dependents and individuals excluded from liability, are required to pay premiums. Exceptions include individuals enrolled in special groups (such as Alberta Widow's Pension or Support for Independence), or people entitled to full premium assistance. Although Albertans are required to pay premiums, no resident is denied coverage due to an inability to pay.

Two programs help lower-income, non-senior Albertans with the cost of their premiums: the Premium Subsidy Program and the Waiver of Premiums Program. Premium assistance for seniors was available under the Alberta Seniors Benefit Program.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

4.2 Coverage During Temporary Absences in Canada

The Alberta Health Care Insurance Plan provided the following coverage to eligible Alberta residents who are temporarily absent within Canada:

☐ Visit/Vacation: up to 24 months coverage;
☐ Work/Business/Missionary Work: up to 48 months; and
☐ Post-secondary Education: no limit (coverage continues until studies are completed).

Requests to extend coverage for a period longer than 24 months are reviewed on a case-by-case basis. Individuals who are routinely absent from Alberta every year normally need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy Alberta Health and Wellness that

Alberta is their permanent and principal place of residence.

Alberta participates in the Hospital Reciprocal Agreement with other provinces and territories. This agreement allows payments for hospital services provided by the host province to residents to be processed. Alberta also participates in the Medical Reciprocal Billing Agreement with provinces and territories (except Quebec). This agreement allows payments for physician services in the host province to be processed. Payments are paid at the host province or territorial rates.

4.3 Coverage During Temporary Absences Outside Canada

The Alberta Health Care Insurance Plan provides coverage for the first six consecutive months of absence outside Canada. Residents who wish to maintain coverage for a longer period may request an extension of coverage for a maximum of 24 consecutive months from the month of departure.

Extension requests for longer than 24 months will be reviewed case-by-case on the same basis as for Albertans living temporarily in another province.

The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day (not including day of discharge). The maximum hospital out-patient per visit rate is $50 (Canadian), with a limit of one visit per day. The only exception is haemodialysis, which is paid at a maximum of $220 per visit, with a limit of one visit per day. Physician and allied health practitioner services are paid according to Alberta rates. More information on coverage during temporary absences outside Canada or Alberta is accessible at **http://www.health.gov.ab.ca/ahcip/pdf/travel.pdf**.

4.4 Prior Approval Requirement

Prior approval is not required for elective services received outside Alberta, except for treating alcohol and substance abuse, eating disorders and similar addictive or behavioural disorders. Approval by the Minister must be received before these services can be covered.

5.0 Accessibiltiy

5.1 Access to Insured Health Services

All Alberta residents have access to provincially funded and insured health services regardless of where they live in the province. Alberta has nine regional health authorities that cooperate with each other in ensuring that all Albertans have access to needed health services. There are two major metropolitan regions, Calgary Health Region and Capital Health (Edmonton), which provide provincially funded, province-wide services to Alberta residents who need tertiary-level diagnostic and treatment services.

5.2 Access to Insured Hospital Services

Alberta Health and Wellness and regional health authorities actively participate in a five-year health workforce planning process to ensure an adequate supply of key personnel.

Health authorities are required to develop capital equipment plans as part of their annual business plan submissions to the Minister of Health and Wellness. Funding for regional health services in 2003-2004 (which includes hospitals and province-wide services) was $4,550 million, an increase of $282 million or 6.6 percent from 2002-2003. The 2003-2004 Alberta Health and Wellness Annual Report can be accessed at **http://www.health.gov.ab.ca/resources/publications/AR03_04/index.html**.

A significant step forward in improving access to insured health services was taken with the development of the Web-based Alberta Waitlist Registry. The registry provides information on wait times for hip and knee replacement surgery, cataract surgery, cardiac surgery and MRI and CT examinations for both hospitals and community providers. The registry is accessible at **http://www.health.gov.ab.ca/waitlist/WaitListPublicHome.jsp**.

5.4 Physician Compensation

Most physicians are compensated through the Alberta Health Care Insurance Plan on a traditional, volume-driven, fee-for-service basis. Alternative relationship plans offer alternative compensation models to the fee-for-service payment system and contribute to better health outcomes by supporting innovative health care delivery.

A new tri-lateral agreement involving the AMA, Alberta Health and Wellness and regional health authorities contains provisions to improve access to physician services. Under this agreement, Alternative Relationship Plans (ARPs) are being established to enhance physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction and value for money. Also under the agreement, local physicians can partner with their health regions to create Local Primary Care Initiatives that will manage 24-hour access to front-line services.

5.5 Payments to Hospitals

Insured hospital services in Alberta are funded through a population-based funding formula for regional health authorities. The health authorities are responsible for planning the allocation of funds for insured hospital services in accordance with regional needs assessments and services plans.

6.0 Recognition

The consolidated financial statements in the Ministry's Annual Report recognize the federal contributions provided under the Canada Health and Social Transfer (CHST). The 2003-2004 Annual Report of the Alberta Ministry of Health and Wellness can be accessed at **http://www.health.gov.ab.ca/resources/publications/AR03_04/index.html**.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004[1]
1. Number as of March 31st (#).	2,957,045	3,007,582	3,072,384	3,124,487	3,165,157

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004[1]
2. Number (#):					
a. acute care	102	102	103	100	102
b. chronic care (Aux. Hospital only)	104	105	106	110	107
c. rehabilitative care	1	1	1	1	1
d. other	3	3	3	3	3
e. total	210	211	213	214	213
3. Payments ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004[1]**
4. Number (#):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available
5. Number of insured hospital services provided (#):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available
6. Payments ($):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	2,545	2,659	2,746	2,841	2,937
b. specialists	2,096	2,197	2,333	2,365	2,426
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	4,641	4,856	5,079	5,206	5,363
8. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	1	0	0	0
c. other	0	0	0	0	0
d. total	0	1	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	15,914,666	16,132,591	16,132,591	16,450,512	16,924,877
b. specialists	11,319,078	11,710,080	11,710,080	12,878,411	13,119,523
c. other	0	0	0	0	0
d. total	27,233,744	27,842,671	27,842,671	29,328,923	30,044,400
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	410,502,506	430,681,658	474,076,958	543,635,736	564,936,923
b. specialists	493,040,446	528,392,197	587,092,735	681,990,901	707,843,059
c. other	0	0	0	0	0
d. total	903,542,952	959,073,855	1,061,169,693	1,225,626,637	1,272,779,982
12. Average payment per fee for service service ($):					
a. general practitioners	25.79	26.70	29.39	33.05	33.38
b. specialists	43.56	45.12	50.14	52.96	53.95
c. other	0.00	0.00	0.00	0.00	0.00
d. all services	33.18	34.45	38.11	41.79	42.36
13. Number of services provided through all payment methods (#):					
a. medical	19,829,029	20,328,498	20,647,611	21,153,134	21,680,907
b. surgical	1,238,043	1,316,312	1,396,422	2,417,363	2,513,638
c. diagnostic	5,274,903	5,588,934	5,798,638	5,758,426	5,849,855
d. other	0	0	0	0	0
e. total	26,341,975	27,233,744	27,842,671	29,328,923	30,044,400
14. Total payments to physicians paid through all payment methods ($):					
a. medical	586,587,852	618,596,110	684,971,654	788,450,446	816,374,918
b. surgical	140,067,988	150,223,933	164,427,152	190,259,821	196,291,136
c. diagnostic	176,887,112	190,253,812	211,770,887	246,916,370	260,113,928
d. other	0	0	0	0	0
e. total	903,542,952	959,073,855	1,061,169,693	1,225,626,637	1,272,779,982
15. Average payment per service, all payment methods ($):					
a. medical	29.58	30.43	33.17	37.27	37.65
b. surgical	113.14	114.12	117.75	78.71	78.09
c. diagnostic	33.53	34.04	36.52	42.88	44.47
d. other	0.00	0.00	0.00	0.00	0.00
e. all services	34.30	35.22	38.11	41.79	42.36

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004[1]
16. Total number of claims, in-patient (#).	4,820	4,656	4,205	4,275	4,651
17. Total number of claims, out-patient (#).	59,443	56,408	61,230	67,975	68,469
18. Total payments, in-patient ($).	13,632,730	14,699,049	12,328,205	15,753,884	19,411,517
19. Total payments, out-patient ($).	6,920,702	5,287,271	7,115,105	7,953,195	7,982,851
20. Average payment, in-patient ($).	2,828.37	3,157.01	2,931.80	3,685.12	4,173.62
21. Average payment, out-patient ($).	116.43	93.73	116.20	117.00	116.59
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004[1]**
22. Number of services (#).	380,635	418,587	493,798	559,503	485,843
23. Total payments ($).	11,397,620	12,436,188	11,998,825	13,880,981	15,139,408
24. Average payment per service ($).	29.94	29.71	24.30	24.81	31.16

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004[1]
25. Total number of claims, in-patient (#).	5,215	4,151	4,457	3,698	3,319
26. Total number of claims, out-patient (#).	5,097	3,945	3,942	3,739	3,405
27. Total payments, in-patient ($).	483,648	374,005	416,635	340,169	300,233
28. Total payments, out-patient ($).	364,087	298,725	309,119	206,684	212,949
29. Average payment, in-patient ($).	92.74	90.10	93.48	91.99	90.46
30. Average payment, out-patient ($).	71.43	75.72	78.42	55.28	62.54
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004[1]**
31. Number of services (#).	21,989	20,891	22,928	21,289	20,753
32. Total payments ($).	871,292	907,010	1,043,997	976,232	963,299
33. Average payment per service ($).	39.62	43.42	45.53	45.86	46.42

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004[1]
34. Number of particpating dentists (#).	250	232	250	234	216
35. Number of services provided (#).	14,292	14,708	14,585	16,759	14,802
36. Total payments ($).	2,092,003	2,116,386	2,167,898	2,394,458	2,404,042
37. Average payment per service ($).	146.38	143.89	148.64	142.88	162.41

Endnotes

1. These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan Statistical Supplement, 2003-2004.

British Columbia

Introduction

British Columbia has a progressive and integrated health care system. The British Columbia health system includes insured services under the *Canada Health Act* as well as services funded wholly or partially by the Government of British Columbia and services regulated by, not funded by, the government. This system is based on regional delivery and self-regulating professions providing quality, accessible and affordable health care.

Five regional health authorities are responsible for managing and delivering a range of health services, including acute and hospital care, home and community care, mental health, addictions, and public health services. These five regional health authorities encompass 15 health services delivery areas, which were established to reflect natural patient referral patterns. In addition to the regional health authorities, the Provincial Health Services Authority coordinates and delivers highly specialized services that cannot be offered in all regions, and facilitates coordination of provincial initiatives. Health authorities receive three-year budgets, which assist in planning, and are accountable to government through performance agreements that define expectations and performance deliverables for three fiscal years. The performance agreements also set out the major change requirements in areas of service such as emergency care, surgical services, home and community care, public and preventive health and mental health.

Health care is a top priority for the Government and people of British Columbia.

Activities for 2003-2004

Over the past year, the Ministry of Health Services has made significant progress in some key goals and priorities for British Columbia's health care system. These include protecting public health, ensuring patients get timely access to appropriate quality care, and planning for a dependable and sustainable health system. We are making progress in every one of these areas.

Maintaining the status quo in British Columbia's health system has not been an option. Over the past decade, health care costs have been rapidly rising and consuming an ever increasing portion of the government's overall budget. With limited resources and greater demands, this trend is not sustainable. Therefore, fundamental changes have to be made.

Making innovative changes and improvements, especially those that challenge long-standing or traditional approaches or methods, is not easy. However, new health research and leading journals show us there are new, creative and efficient ways of improving health care and health outcomes for British Columbians. This means making some difficult decisions, and we are now well on our way to re-engineering and redesigning the health system to meet British Columbians' diverse needs in a sustainable way. British Columbians – patients, care providers and the public – are beginning to see positive results from the long-term planning and hard work being undertaken across the health sector.

Significant achievements in 2003-2004 include:

Protecting Public Health

The Minister of Health Services approved an additional $800,000 in annual funding to expand the provincial immunization program for British Columbian children to include protection for adolescents from whooping cough. In addition, $9.6 million in base funding was provided to health authorities to annualize the pneumococcal and meningococcal high-risk program implemented the previous year.

New measures governing drinking water help to protect the health and safety of British Columbians. The amended *Drinking Water Protection Act* and Regulations came into force on May 16, 2003. The changes establish a comprehensive and coordinated framework for protecting the province's drinking water from source to tap.

A project to renew the *Health Act* (British Columbia's primary Public Health legislation) was initiated in 2003. This project will complete the modernization of British Columbia's public health legislation, complementing the newly developed *Drinking Water Protection Act* and *Food Safety Act*. In 2003 BC continued development of "Core Programs in Public Health", a project designed to establish the core requirements for public health service delivery.

British Columbia invested $2.6 million for research to accelerate the development of a vaccine against SARS. In addition, the British Columbia obtained a permit under the *Pesticide Control Act* to control mosquitoes should they pose a public health risk due to the West Nile Virus.

The BC Centre for Disease Control and the Michael Smith Genome Sciences Centre are placing British Columbia at the forefront of Canada and the world in health research. The ministry has contributed $15 million to Genome BC, one of five not-for-profit genome centres established to coordinate genomics research in Canada. Genome BC research includes developing ways to track how cells transform into malignancies and become cancerous.

The government has provided over $24 million to the Michael Smith Foundation for Health Research for new programs in British Columbia which continue to develop, attract and retain outstanding health scientists and researches. This funding supports research in priority areas such as health care re-engineering and innovation.

Providing High Quality, Patient Centred Care

Supported by an investment of $73.5 million over four years, through the Primary Care Transition Fund, British Columbia's health authorities have been implementing a range of initiatives to support more comprehensive, coordinated and accessible primary health care services. Initiatives include: networks linking family physician practices; community health centres; shared care arrangements providing family practices with specialist consultation and expertise; nurse managed care in regions with limited access to physicians; and chronic disease management. This funding also supported the Ministry of Health Services' addition of pharmacist services to the BC NurseLine and creation of the Chronic Disease Management Toolkit for Practitioners, using secure web-based technology to provide tools and information to support optimal chronic disease management.

In 2003, British Columbia invested $2.8 million on expanded resources for doctors to help them better manage the care they provide to patients suffering from chronic diseases. The funding is targeted for doctor- and medical-related organizations with the aim of improving professional development opportunities for doctors in the areas of preventative care and managing ongoing conditions of chronic illness.

In September 2003, the $20 million Full Services Family Incentive Program was implemented, supporting physicians through new standardized patient-care guidelines of treatment for patients with diabetes or congestive heart failure. Physicians will be compensated for each patient successfully involved in the treatment plan, with the goal of having fewer disease-related complications with less need for hospitalization and associated health-care costs. The second component of the program encourages doctors to continue delivering babies in their communities.

Renal services have been expanded beyond the major urban centres with new kidney dialysis services in Kelowna, Penticton, Creston, Terrace and Nanaimo.

New investments in telehealth technology allow patients to access the specialist care they need from BC Children's, Sunny Hill and BC Women's

Hospitals without having to travel from their own communities.

New funding of $1.3 million per year for cochlear implants was announced in December 2003 to significantly reduce wait times for adults and children awaiting this surgery.

Managing for Sustainability

The end of the 2003-2004 fiscal year marks the mid-way point in a three-year process to achieve a more accountable, patient-centered and coherent system of health care in British Columbia.

In 2002-2003, the formation of British Columbia's new health authorities created a strong foundation for making fundamental improvements to the management and delivery of hospital and community based health services. In 2003-2004, their second full year of operation, health authorities took significant strides toward meeting the specific challenges set out in the Performance Agreements[1] and began to fully assume their role in shaping British Columbia's overall health care system.

With the expectation to implement service redesign and improvement initiatives within available funding, health authorities are making system improvements largely by redirecting and reallocating existing funding to maximize the benefit to patients and return on investment.

Health authorities are guided in their strategies by the priority strategies outlined by government through the Ministry of Health Services' three year Service Plan.

The ministry and health authorities continue to work together to develop performance measurement, monitoring and evaluation processes to improve health care, and increase accountably in the health care system in British Columbia.

Fair PharmaCare was implemented on May 1, 2003, as an equitable way to offer British Columbia families assistance with prescription drug costs based on family income.

Before Fair PharmaCare, many families with low incomes were paying more for their prescription drug costs than those with higher incomes. Fair PharmaCare helps to address these inequities by focusing on financial assistance to those families that need it most. Under Fair PharmaCare, the majority of British Columbia families pay the same or less for prescription drugs than they did before the new plan.

In October 2003, the *Health Professions Amendment Act* was passed in the legislature allowing for the regulation of nurse practitioners. The new program of nurse practitioners improves health services by expanding the range of health professionals to care for patients.

The $700,000 Interprofessional Rural Program of British Columbia was announced in May 2003. This program unites teams of students from different health-care disciplines and provides opportunities for qualified students to be placed in small and remote communities for periods of 10 to 12 weeks. The students gain hands-on clinical experience and patients in rural and remote areas gain more health services immediately.

In April 2003, the Minister of Health Services appointed a community advisory group, (the UNBC Northern Medical Program Community Action Group), to focus on promoting a successful northern medical school program and making Prince George a strong regional health centre. The advisory group produced a report, *Building for the Future of Health Care in Northern BC*, which focuses on the recruitment and retention of core clinicians as well as improving appropriate use of hospital care in the north and providing academic support. The Minister of Health Services announced in March 2004 that $2.2 million is being invested in response to the report which contains recommendations promoting the success of the Northern Medical program and making Prince George a centre of excellence in rural and remote health care.

---

[1] In April 2002, the government introduced Performance Agreements between the new health authorities and the BC Ministry of Health Services as a means of increasing accountability for the delivery of patient services, health outcomes and health care spending. The Performance Agreements define expectations, performance deliverables and service requirements in the areas of emergency care, surgical services, home and community care, and mental health services for three fiscal years.

Significant improvements to the regulatory framework for health professions in British Columbia were accomplished in 2003. The umbrella framework of the *Health Professions Act* was enhanced significantly by implementing recommendations of the former Health Professions Council in its 2001 report, *Safe Choices: A New Model for Regulating Health Professions in British Columbia.*

The *Health Professions Amendment Act*, 2003 extends the umbrella framework to all health professions, and provides for the repeal of six stand-alone statutes governing medicine, optometry, dentistry, podiatry, chiropractic services and registered nursing. In addition, pharmacy is to be regulated under the *Health Professions Act* and the new *Pharmacy Operations and Drug Scheduling Act* will replace the *Pharmacists, Pharmacy Operations and Drug Scheduling Act.*

Information on health and health care in British Columbia is available from the following website:

www.gov.bc.ca/healthservices

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

On January 1, 1949, the British Columbia provincial government commenced making payments to hospitals for treatment provided to qualified residents under the authority of the *Hospital Insurance Act*. Hospital services are funded, on a non-profit basis, through the Regional Health Sector budget of the Ministry of Health Services. This program is responsible to the provincial government for the ongoing funding of the province's public hospitals, delivered via funding and transfer agreements with the six health authorities, under the terms of the *Hospital Act*, the *Hospital Insurance Act* (section 9), and the *Hospital District Act* (section 20).This entails expenditures and commitment controls for the operation of hospitals, provision of funds for hospital construction and equipment and payment of out-of-province hospital costs for qualified British Columbia residents.

The Medical Services Plan of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission. The Medical Services Commission is responsible to the Minister of Health Services and facilitates, in the manner provided for under the *Medicare Protection Act*, reasonable access to insured benefits under British Columbia's Medical Services Plan by beneficiaries (residents). The day-to-day administration is currently carried out by employees of the Medical Services Plan of the Ministry of Health Services. Beginning in April 2005, routine administrative functions will be delivered by a private sector service provider. In addition to its role in managing the contract with the private provider, the ministry will continue to be accountable for overall service delivery and will retain responsibility for areas such as legislation, regulations, setting of policy, complex decisions and appeals.

The Commission's powers (set out under section 5 of the *Medicare Protection Act*) include determining benefits, registering beneficiaries, enrolling practitioners, processing and paying practitioners' bills for benefits rendered, registering diagnostic facilities, establishing advisory committees, authorizing research and surveys related to the provision of benefits, auditing claims for payment and patterns of practice or billings submitted and hearing appeals from practitioners and beneficiaries.

In May 2003, the *Health Services Statutes Amendment Act*, 2003, was passed by the Legislature. It made minor amendments to the *Food Safety Act*, *Hospital Insurance Act*, and *Medicare Protection Act*. As amended, the *Medicare Protection Act* authorizes the making of rules by the Medical Services Commission concerning practice and procedure for applications, for orders and replies, and for the conduct of hearings. The Ministry of Health Services will also have recourse to order mediation to resolve disputes regarding medical service plan billings. Amendments to the *Hospital Insurance Act* reflect the new regional structure of health-care delivery as well as the fact that ministry funding now goes directly to health authorities rather than to individual hospitals.

1.2 Reporting Relationship

Health authorities are required to report health information data respecting hospitals in their jurisdictions to the Ministry of Health Services in accordance with provincial policy. The Performance Management and Improvement Division reports to government through the *Ministry of Health Services Annual Service Plan Report*. This report compares actual results for the preceding fiscal year with the expected results identified in the service plan for that fiscal year. In accordance with the *Budget Transparency and Accountability Act*, this report, as well as the *Ministry of Health Services Service Plan*, is made public by the minister.

The Medical Services Commission reports annually to the Minister of Health Services in a separate Financial Statement. The 2003-2004 Financial Statement was tabled in June 2004.

In the Annual Service Plan Report, the Ministry of Health Services provides extensive information on the performance of British Columbia's publicly funded health care system. Tracking and reporting this information is consistent with the ministry's increasingly strategic approach and responsibilities for performance planning and reporting, under the *Budget Transparency and Accountability Act*, which was passed in 2000.

The Ministry of Health Services plays a role in various reports including:

- ☐ Ministry Annual Report
- ☐ Report on Health Authority Performance (annual)
- ☐ Nationally comparable Indictors Report
- ☐ Provincial Health Officer's Annual Report (on the health of the population)

1.3 Audit of Accounts

The ministry is subject to audit of accounts and financial transactions through two types of auditor:

- ☐ The Office of the Comptroller General's Internal Audit and Advisory Services is the provincial government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry of Health Services.
- ☐ The Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the ministry has complied with the audit recommendations.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Act* establishes public insurance coverage for general hospital services. Eligibility is defined by the Regulations, which include both a residency requirement and a waiting period. Insured hospital services are provided in facilities specified in section 1 of the *Hospital Insurance Act*. In 2003-2004 there were 92 acute care hospitals, three rehabilitation hospitals, 18 free-standing extended care hospitals and 24 diagnostic and treatment and other health centres.

Insured hospital services are provided as recommended by the attending physician or midwife. These services, and the conditions under which they are provided, are listed in the Hospital Insurance Act Regulations, Division 5. Insured in-patient services provided by hospitals are:

- ☐ accommodation and meals at the standard or public ward level;
- ☐ necessary nursing services;
- ☐ laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the minister in a particular hospital with the necessary interpretations, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of illness, injury or disability;
- ☐ clinically approved drugs, biologicals and medical supplies, when administered in a general hospital specified in the *Hospital Insurance Act*;
- ☐ routine surgical supplies;
- ☐ use of operating room and case room facilities;
- ☐ anaesthetic equipment and supplies;
- ☐ use of radiotherapy, physiotherapy and occupational therapy facilities, where available; and
- ☐ other services approved by the Minister that are rendered by persons who receive remuneration from the hospital.

Beneficiaries not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room services for surgical day care and minor surgery, including the application and removal of casts.

Listed hospital out-patient benefits include:

- ☐ out-patient renal dialysis treatments in designated hospitals or other approved facilities;
- ☐ diabetic day-care services in designated hospitals;
- ☐ out-patient dietetic counseling services at hospitals with qualified staff dieticians;
- ☐ psychiatric out-patient and day-care services; physiotherapy and rehabilitation out-patient day care, and services;
- ☐ cancer therapy and cytology services;
- ☐ out-patient psoriasis treatment;
- ☐ abortion services; and
- ☐ MRI services.

Insured hospital services are provided at no charge to beneficiaries. Incremental charges for preferred medical/surgical supplies, when approved, are made on the basis of a patient's request. The patient is not required to pay the incremental charge if the preferred service is deemed medically necessary by the attending physician.

Ambulance services are provided within the province by the British Columbia Ministry of Health Services through the Emergency Health Services Commission, with a partial charge to the patient.

There is no regular process to review insured hospital services. As the list of insured services included in the Regulations is intended to be both comprehensive and generic, it does not require routine review and updating.

2.2 Insured Physician Services

Insured physician services are provided under the authority of the *Medicare Protection Act*. Section 13 of the *Medicare Protection Act* (MPA) provides that practitioners (including medical practitioners and health care practitioners, such as dentists) who are enrolled and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

The Medical Services Plan (MSP) provides for medically required services of medical practitioners. Unless specifically excluded, the following medical services are insured as MSP benefits under the MPA and in accordance with the *Canada Health Act*:

- ☐ medically required services provided to "beneficiaries" (residents of British Columbia) by a medical practitioner enrolled with MSP; and
- ☐ medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with the MSP.

There were 8,083 physicians enrolled and billing fee-for-service in fiscal year 2003-2004. In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) arrangements with the health authorities. Many physicians paid by such alternative mechanisms also practice on a fee-for-service basis.

A physician may choose not to enroll or to de-enroll with the Medical Services Commission. Enrolled physicians may cancel their enrollment by giving 30 days' written notice to the Commission. Services provided by non-enrolled physicians are not benefits and patients are responsible for the full cost of the service. There was one previously enrolled physician who had de-enrolled as of March 31, 2004.

Enrolled physicians can elect to be paid directly by beneficiaries by giving written notice to the Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, beneficiaries may apply to the MSP for reimbursement of the fee for insured services rendered. Only six physicians had elected to be paid in this manner as of March 2004.

Under the Master Agreement between the Government, the Commission and the British Columbia Medical Association (BCMA), additions, deletions, fee changes or other modifications to the Commission Payment Schedule are made by the Commission, upon advice from the BCMA. Physicians who wish to have modifications to the Schedule considered submit their proposals to the BCMA Tariff Committee through the appropriate section of the BCMA. On recommendation of the BCMA Tariff Committee, interim listings may be designated by the Commission for new procedures or other services for a limited period of time to allow definitive listings to be established, if appropriate.

A number of new or revised clinical practice guidelines were also approved by the Commission in 2003-2004:

☐ initiation and maintenance of Warfarin therapy;
☐ treatment of patients over-anticoagulated with Warfarin;
☐ management of Warfarin therapy during invasive procedures and surgery;
☐ diabetes care (revised 2004);
☐ detection of colorectal neoplasms in asymptomatic patient;
☐ identification, evaluation and management of patients with chronic kidney disease;
☐ microscopic hematuria (persistent);
☐ diagnosis and management of major depressive disorder;
☐ clinical approach to adult patients with dyspepsia (revised 2004);
☐ follow-up of patients after curative resection of colorectal cancer (revised 2004);
☐ evaluation and interpretation of abnormal liver chemistry in adults;
☐ clinical approach to adult patients with gastroesophageal reflux disease (revised 2004);
☐ thyroid function tests in the diagnosis and monitoring of adults with thyroid disease; and
☐ primary care management of sleep complaints (revised 2004).

2.3 Insured Surgical-Dental Services

The Medical Services Plan provides for specified dental or oral surgery when it is medically or dentally necessary for it to be performed in hospital by a dental or oral surgeon. Surgical-dental services are covered by the Medical Services Plan when hospitalization is medically required for the safe and proper performance of the surgery and the procedure is listed in the Dental Payment Schedule. The *Medicare Protection Act* defines patient eligibility and provider criteria. Additions or changes to the list of insured services are managed by the Medical Services Plan on the advice of the Dental Liaison Committee, which has equal representation from the Dental Association and the Ministry of Health Services. Additions and changes must be approved by the Medical Services Commission. Included as insured surgical-dental procedures are those related to the remedying of a disorder of the oral cavity or a functional component of mastication. Generally this would include, oral surgery related to trauma, orthognathic surgery, medically required extractions, and surgical treatment of temporomandibular joint dysfunction.

Any dental or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the Medical Services Plan may provide insured surgical-dental services in hospital. There were 243 dentists enrolled and billing fee-for-service in 2003-2004. None have de-enrolled and none have opted out of the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial Pharmacare program. Other procedures not insured under the *Hospital Insurance Act* are:

☐ the services of medical personnel not employed by the hospital;
☐ treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible;
☐ services solely for the alteration of appearance; and
☐ reversal of sterilization procedures.

Uninsured hospital services also include:

☐ preferred accommodation at the patient's request;
☐ televisions, telephones and private nursing services;
☐ preferred medical/surgical supplies;
☐ dental care that could be provided in a dental office including prosthetic and orthodontic services; and
☐ preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan include:

☐ those covered by the *Workers' Compensation Act* or by other federal or provincial legislation;
☐ provision of non-implanted prostheses;
☐ orthotic devices;
☐ proprietary or patent medicines;
☐ any medical examinations that are not medically required;
☐ oral surgery rendered in a dentist's office;
☐ acupuncture;
☐ telephone advice unrelated to insured visits;
☐ reversal of sterilization procedures;
☐ *in-vitro* fertilization;
☐ medico-legal services; and
☐ most cosmetic surgery.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services.

The *Medicare Protection Act*, section 45 prohibits the sale or issuance of health insurance by private insurer to beneficiaries for services that would be benefits if performed by a practitioner. Section 17 of the Act prohibits persons from charging a beneficiary for a benefit or for "materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit." The Ministry of Health Services responds to complaints made by patients and is prepared to take appropriate actions to correct situations identified to the ministry.

In September 2002, the Ministry of Health Services issued a Policy Communiqué to all health authorities on Hospital-Based Revenue Generation. Among the categories of services covered by this policy is use of hospital facilities to provide services covered by third party insurers, such as the Workers' Compensation Board. The policy specifies that health authorities' primary obligation is to provide insured health services to beneficiaries, and that revenue generating practices must not occur at the expense of providing appropriate and timely service to beneficiaries. It also reinforces that health authorities must follow the requirements of the *Canada Health Act*, as well as relevant provincial legislation. Health authorities are required to report new initiatives of this type within their annual Health Service Plans, and the

Ministry of Health Services monitors compliance with the policy within the overall performance monitoring plan and service design plans.

The Medical Services Commission determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the British Columbia Medical Association's Tariff Committee. No services were de-listed in 2003-2004.

3.0 Universality

3.1 Eligibility

Provincial policy on eligibility for hospital services is set out in Chapter 2 of the Ministry of Health Service's Acute Care Policy Manual.

Section 7 of the *Medicare Protection Act* defines the eligibility and enrollment of beneficiaries for insured services. Part 2 of the Medical and Health Care Services Regulation made under the *Medicare Protection Act* details residency requirements. A person must be a resident of British Columbia in order to qualify for provincial health care benefits. The *Medicare Protection Act*, in section 1, defines a resident as a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in British Columbia, and is physically present in British Columbia at least six months in a calendar year. The definition of resident includes a person who is deemed under section 2 of the Medical and Health Care Services Regulations to be a resident but does not include a tourist or visitor to British Columbia.

All residents, excluding those eligible for compensation from another source, are entitled to hospital and medical care insurance coverage. The Medical Services Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia, they must wait the prescribed period.

3.2 Registration Requirements

Residents must be enrolled in the Medical Services Plan to receive insured hospital and physician services. Those who are eligible for coverage are required to enroll. Once enrolled, there is no expiration date for coverage. New residents are advised to make application immediately upon arrival in the province. Each person who enrolls with the Medical Services Plan is issued a CareCard. Renewal of cancelled enrollment can usually take place over the telephone, by calling the Medical Services Plan.

Beneficiaries may cover their dependents, provided the dependents are residents of the province. Dependents include the account holder's spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward, supported by the beneficiary, and either under the age of 19 or under the age of 25 and in full-time attendance at a school or university.

The number of residents registered with the Medical Services Plan as of March 31, 2004, was 4.10 million. Enrollment in the Medical Services Plan is mandatory. Only those adults who formally opt out of all provincial health care programs are exempt. As of March 31, 2004, 173 people had opted out.

3.3 Other Categories of Individual

Refugee claimants are not generally eligible for benefits. Individuals who are approved for refugee status and who are, therefore entitled to reside in Canada on a permanent basis, are eligible. Under specific circumstances, special consideration is given to these individuals regarding the effective date of benefits. Holders of Minister's Permits/Temporary Resident Permits are eligible for benefits where deemed to be residents under the Medical and Health Care Services Regulation. A waiting period applies which consists of the balance of the month in which a person first meets the Medical Services Plan's definition of a resident, plus two months.

3.4 Premiums

Enrollment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrollment eligibility criteria. Monthly premiums for the Medical Services Plan are $54 for one person, $96 for a family of two, and $108 for a family of three or more. Residents with limited incomes may be eligible for premium assistance. There are five levels of assistance, ranging from 20 percent to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have been resident in Canada and a Canadian citizen or holder of permanent resident (landed immigrant) status.

There are no additional premiums for insured hospital services. However, there is a daily charge for extended-care hospital services for patients over the age of 19. The client rate, representing the cost of accommodation and meals, is established once a year. As of March 31, 2004, the rates ranged from $27.60 a day to $66.30 a day, depending on client income. In certain circumstances where clients cannot afford to pay their assessed rate, there is a provision to waive a portion of the daily fee. Client rates are increased on January 1st of each year by the percentage increase in the Consumer Price Index.

4.0 Portability

Persons moving permanently to another part of Canada are entitled to coverage to the end of the second month following the month of departure. Such persons may be extended coverage, not to exceed three months, for a reasonable period of travel.

Persons moving permanently outside Canada are entitled to coverage to the end of the month of departure.

4.1 Minimum Waiting Period

The minimum residence requirement for hospital insurance and medical care coverage is a waiting period ending at midnight on the last day of the second month following the month in which the individual becomes a resident.

Coverage is available to landed immigrants who have completed the waiting period. Also after the waiting period, coverage is available to persons from outside Canada who are in the Province on work permits or student visas, provided the permits or visas are valid for at least six months, and have been issued at the time of admission to Canada.

4.2 Coverage During Temporary Absences In Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulations define portability provisions for persons temporarily absent from British Columbia in Canada with regard to insured services. In 2003-2004, there were no amendments to the Medical and Health Care Services Regulation, made under the *Medicare Protection Act*, with respect to the portability provisions.

Section 17 of the *Hospital Insurance Act* empowers the Minister of Health to enter into an agreement with any other province or territory to bring about a high degree of liaison and cooperation among the Provinces concerning hospital insurance matters, and to make arrangements under which a qualified person may move his or her home from one province or territory to the other without ceasing to be entitled to benefits.

Individuals who leave the province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Approval is limited to once in five years for such absences exceeding six months in a calendar year.

Residents who spend part of every year outside British Columbia must be physically present in Canada for at least six months in a calendar year and continue to maintain their homes in British Columbia. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to inter-provincial and inter-territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, on presentation of a valid Medical Services Plan Card (CareCard). British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and interterritorial reciprocal billing procedures. In 2003-2004, the total amounts paid to other provinces and territories for both in-patient and out-patient hospital services was $56.4 million. The amount paid to physicians in other provinces and territories was $24.2 million.

As Quebec does not participate in reciprocal billing agreements for physician services, claims for services provided to British Columbia beneficiaries by Quebec physicians must be handled individually. Reimbursement may be made either to the physician providing the service, or directly to the beneficiary who received the service, whomever submits the claim.

4.3 Coverage During Temporary Absences Outside Canada

The Hospital Insurance Act Regulations, division 4 and sections 3, 4, and 5 of the Medical and Health Care Services Regulations define portability of insured hospital and physician services during temporary absences outside Canada. In 2003-2004, there were no amendments to the Medical and Health Care Services Regulation with respect to portability provisions.

A qualified person leaving British Columbia to attend university, college or other educational institutions recognized by the Medical Services Commission, on a full-time basis, retains eligibility during the absence for study until the last day of the month in which the person ceased full-time attendance at that educational institution, or if studying outside Canada, the last day of the sixtieth month since the date of departure from British Columbia.

A qualified person who is absent from British Columbia for vacation or work for more than six months is deemed a resident for the purpose of determining beneficiary status for up to the initial 12 consecutive months of absence, if this person obtains prior approval from the Medical Services Commission, does not establish residency outside British Columbia and has not been granted approval for a similar absence during the preceding 60 months.

With prior authorization, coverage is provided for hospital services not available in Canada at the hospital's usual and customary rate. In other circumstances, with prior authorization, in-patient coverage is at the established standard ward rate. Out-patient renal dialysis treatment is available at the interprovincial and interterritorial Canadian rate. In all other cases, including emergency or sudden illness during temporary absences from the Province, in-patient hospital or daycare surgical care is paid up to $75 Canadian per day for adults and children, and $41 Canadian per day for newborns. Payments for insured services provided outside Canada in 2003-2004 totaled $2.7 million to hospitals and $2.5 million to physicians.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements. Some treatments may require the approval of Performance Management and Improvement Division (e.g., treatment for anorexia). All non-emergency procedures performed outside of Canada require approval from the Commission prior to the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

British Columbia believes that all residents have reasonable access to hospital and medical care services. Beneficiaries, as defined in section 1 of the *Medicare Protection Act* and the Ministry of Health Services' Acute Care Policy Manual, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, Part 4, prohibits extra-billing by enrolled practitioners.

5.2 Access to Insured Hospital Services

The number of practicing Registered Nurses as of December 2003 was 29,982. British Columbia hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2003 there were 2,149 RPNs and 4,923 LPNs. In September 2003 the British Columbia government announced that a further $6.7 million would be added to its nursing strategy to continue to strengthen recruitment, retention and education of nurses across BC. Since August 2001, government's total commitment to nursing strategies has grown to $59 million.

British Columbia's nursing strategies are identified, developed and implemented by the Ministry of Health Services with input from nurses and other stakeholders. They are intended to improve the recruitment, retention, education and workplace needs of British Columbia nurses and nursing students. Through consultation with stakeholders, input from the Nursing Advisory Committee of BC and review of national trends and policies, the following priorities were identified:

- ☐ human resources planning for recruitment, retention and education of nurses in British Columbia to address provincial health care needs;
- ☐ enhancing nursing practice environments by supporting health authorities and government to make sound nursing policy in keeping with current research and provincial, national and global trends;
- ☐ compiling nursing data to enhance our understanding of trends and changing needs in nursing and health care; and
- ☐ promoting nursing as a career of choice to ensure the future of a quality British Columbia health care system.

In October 2003, the *Health Professions Amendment Act* was passed in the Legislature allowing for the regulation of nurse practitioners. Thirty new spaces for nurse practitioners were added at the University of British Columbia and University of Victoria in September 2003. An additional 15 new student spaces at University of Northern British Columbia was announced in March 2004.The new program of nurse practitioners improves health services by expanding the range of health professionals to care for patients. Nurse practitioners are one component of the province's primary-care initiative, which is aimed at providing a broader range of integrated health services that are more appropriate to meet the needs of patients.

British Columbia midwives are publicly funded and perform 4 percent of total annual births in British Columbia. This percentage is expected to increase by 2005 due to student graduation from the new UBC School of Midwifery. As of December 2004, there were 101 midwives practicing throughout British Columbia. Midwives are practicing within both rural and urban settings; however, 75 percent of midwives are working in urban settings.

Telehealth (supported by the Provincial Health Services Authority since mid 2002) continues to provide improved access to services in British Columbia.

March 31, 2003 marked the conclusion of the federal funding period through the Canada Health Infostructure Partnerships Program (CHIPP), and the regional health authorities now support the equipment and infrastructure deployed during CHIPP.

Services established through the different projects continue to be delivered, and new applications are being implemented on an ongoing basis. Four domains in Telehealth have now been defined: Telemedicine, Telehomecare; Telelearning and Teletriage. There is growing focus on increasing access to Telehealth in aboriginal, rural and remote, and First Language Minority communities.

With respect to active Telehealth programs in the province of British Columbia, services are available in approximately 20 clinical program areas. Oncology, mental health/psychiatry, maternal/fetal medicine, medical genetics, orthopedics, pharmacy, thoracic surgery, trauma, and wound care program areas are all applying telehealth technology to service delivery. Services for children are available in the areas of psychiatry, rehabilitation and development, eating disorders/nutrition, neonatology, cardiology, oncology, palliative care, physiotherapy, and speech therapy.

A provincial Telehealth Steering Committee is in the process of identifying and defining the provincial priorities for telehealth.

Acute care access standards are used by health authorities in the redesign of hospital services. The standards specify the maximum travel time for accessing emergency services, in-patient services and core specialty services. They also ensure that the majority of British Columbians, in all regions, have reasonable access to these services. Within the Ministry of Health Services Service Plan 2002/2003 - 2004/2005, performance measures were included regarding waiting times for key services (radiotherapy and chemotherapy). For 2003-2004, the targets for both chemotherapy and radiotherapy were met.

Over the past year, the Ministry of Health Services has continued to work with health authorities to improve capital planning and processes to better serve the needs of the health sector. Ongoing implementation of the new provincial capital policy framework (*Capital Asset Management Framework, 2002*) promotes best practices and supports a more flexible approach to meeting service delivery needs. In 2003-2004, in accordance with the *Framework* guidelines, health authorities prepared capital plans designed to more clearly integrate capital planning with redesign and budget plans, and to enhance a more strategic approach to providing capital assets such as hospital facilities and equipment. A more rigorous approach to planning will encourage efficient use of health care dollars to meet increasing demand upon existing assets, and to allow health authorities to maintain and upgrade capital stock.

The ministry provides capital funding to health authorities for maintenance, renovation, replacement and expansion of health facilities. For the 2003-2004 fiscal year, the ministry's multi-year capital spending plan included:

☐ $115 million in general funding to maintain and improve facilities and to purchase equipment;

☐ ongoing expenditures from a $100 million allocation established in 2002-2003 to convert existing health facilities to uses consistent with regional and provincial priorities, achieve building and operational efficiencies, and implement best practices;

☐ ongoing expenditures from a $138 million allocation established in 2002-2003 for development of mental health beds from Riverview Hospital to be relocated to suitable locations in the health regions; and

☐ The first year of funding from the 2003 First Ministers' Accord on Health Care Renewal. Of the $1.5 billion national fund, $200.1 million has been allocated to British Columbia for acquisition of diagnostic and medical equipment, and specialized training of staff. In

2003-2004, health authorities purchased equipment totaling $21.7 million, including:

  - diagnostic imaging equipment (e.g. Computed Tomography scanners);
  - equipment for other diagnostic and therapeutic use (e.g. laboratory equipment);
  - medical and surgical equipment (e.g. anesthetic machines); and
  - equipment for comfort and safety (e.g. lifting devices, mobility aids).

In 2003-2004, the ministry commenced a province-wide inventory and assessment of health authority-owned facilities, land, major equipment and leased premises. This is the first time that such a comprehensive inventory of public and not-for-profit health system assets has been conducted in British Columbia, and it is anticipated the results will significantly enhance decision-making for health authorities. A comprehensive database will allow health authorities to compare assets in a more meaningful way, prioritize projects, and assess the nature and cost of capital investment required to meet future service delivery needs.

The BC HealthGuide Program, started in 2001, has a comprehensive approach to self-care unique in Canada, and based on information delivered in a variety of formats:

- BC HealthGuide Handbook – delivered free to every household in British Columbia, it contains tips for prevention and early identification of illnesses, when to see a doctor, self-care "home treatment" tips, and information on managing chronic diseases. A French version of the handbook was released in June 2004 (Guide-santé – Colombie-Britannique). The BC First Nations Health Handbook was developed in partnership with the BC First Nations Chiefs' Health Committee – the handbook provides specific information on health services available to Aboriginal communities. The BC First Nations Health Handbook was distributed to Aboriginal communities in January 2003. The handbook provides Aboriginal communities with tools and information necessary to help improve their health.
- BC HealthGuide OnLine – expands on the information in the BC HealthGuide Handbook with more than 35,000 medically reviewed pages covering over 3,000 detailed health topics on symptoms and conditions. The Web site, **www.bchealthguide.org** is updated quarterly.
- BC NurseLine – toll-free 24 hours a day, seven days a week nursing triage and health education by telephone. Registered nurses are specially trained to use medically approved protocols for acute and chronic health symptoms and conditions. The BC NurseLine gives people the information they need, when they need it, where they need it, and includes services for people who are deaf and hearing impaired as well as translation services in over 130 different languages - improving access for all British Columbians. In 2003-2004, the BC NurseLine received 250,018 calls – an increase of 44.6 percent over the previous year.
- On June 19, 2003, the pharmacist enhancement to the BC NurseLine was implemented. Callers from British Columbia can speak with a pharmacist about medication related questions, between 5:00 pm and 9:00 am, seven days a week, 365 days per year.
- Since the implementation of the pharmacist advice line, 10,742 medication-related calls were transferred from the BC NurseLine to the BC NurseLine pharmacists. Over this period, 1,118 calls were identified as being triggered by adverse drug reactions – over 10 percent of all medication-related calls transferred from the BC NurseLine. As a result of these calls, BC NurseLine pharmacists have submitted 324 Adverse Drug Reaction (ADRs) Reports to the British Columbia Regional ADR Centre. These are submitted in turn to Health Canada to monitor adverse effects that are either unexpected, serious, or for newly marketed medications. The pharmacist service is responsible for over 20 percent of all ADR reports submitted to Health Canada by the British Columbia Regional ADR Centre, making

it a large and integral contributor to patient safety – not only for British Columbians, but for all Canadians.

☐ BC Health Files – a series of over 170 one-page, easy-to-understand fact sheets about a wide range of public and environmental health and safety issues. The fact sheets are available in the province's 120+ health units and departments and other offices.

5.3 Access to Insured Physician and Surgical-Dental Services

In 2003-2004, there were 4,573 general practitioners, 3,510 specialists and 243 dentists who provided insured fee-for-service physician and dental-surgical services. Approximately 2,292 general practitioners and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP). The APP provides funding to regional health authorities for their contracting with physicians for the delivery of insured clinical services.

The Ministry of Health Services implemented several programs under the 2002 Subsidiary Agreement for Physicians in Rural Practice to enhance the availability and stability of physician services in smaller urban, rural and remote areas of British Columbia. The Rural Retention Program provides eligible rural physicians (approximately 1,200) with fee premiums and is available for visiting physicians and locums. Through the Northern and Isolation Travel Assistance Outreach Program, funding was provided for an estimated 1,400 visits by family doctors and specialists to rural communities. The Rural General Practitioner Locum Program assisted physicians practicing in approximately 55 small communities to secure subsidized continuing medical education and vacation relief. The Rural Specialist Locum Program provides locum support for core specialists in 17 rural communities while physician recruitment efforts are underway. The Rural Education Action Plan supported the training of physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practising physicians. Effective April 1, 2004, the Isolation Allowance Fund was established to provide funding to communities with fewer than four physicians and no hospital and which do not receive Medical On-call/Availability Program, call-back, or Doctor of the Day payments. The Rural Loan Forgiveness Program decreases BC student loans by 20 percent for each year of rural practice for physicians, nurses, midwives and pharmacists.

In November 2002, British Columbia received $73.5 million in federal funding over four years (2002-2006) to develop sustainable improvements to primary health care (PHC) and increase patient access to comprehensive, high-quality services in physicians' offices and community clinics - the usual first points of contact with the health care system. Since 2002, the number of new model PHC sites, providing interdisciplinary care and extended hours, has increased to a total of nine sites. Regional health authorities have plans to establish up to 30 PHC sites by March 2006.

The University of British Columbia's (UBC) medical school is expanding in collaboration with the University of Northern British Columbia, the University of Victoria and British Columbia's health authorities to almost double the number of medical students. In 2002, as part of British Columbia's commitment to expand the province's only medical school, the provincial government announced $134 million to build a new Life Sciences Centre at UBC in Vancouver and distributed sites for medical programs in Prince George and Victoria. In 2004, the number of first-year medical school spaces increased to 200, up from 128 in 2003. A further increase of 24 spaces in 2005 means UBC will graduate a potential of 224 medical students per year by 2009.

In addition to the medical school expansion, the government has begun a stepped expansion to postgraduate medical education. Thirty-two first-year residency positions were added in 2004. By 2010, the number of first-year postgraduate positions will double to 256, up from 128 in 2003.

5.4 Physician Compensation

The Province of British Columbia negotiates with the British Columbia Medical Association (BCMA) to establish the conditions, benefits and overall compensation for both fee-for-service physicians and physicians paid under alternative payment mechanisms, including contracted, sessional and salaried physicians.

Physicians in British Columbia received significant increases in 2002, placing them among the highest compensated in all of Canada. Funding for physicians accounts for over $2.5 billion or 23 per cent of the health care budget. In June 2004 the Government and BCMA, signed three Letters of Agreement pertaining to the Working Agreement, Laboratory Reform and Related Matters. The agreement reallocates $100 million of savings to improve the quality of patient care.

The three-year contract puts physician compensation increases on hold for two years, expands communications between government and physicians through a variety of committees and consultations, reallocates benefit funds, improves maternity care, provides additional funding for recruitment and retention of rural physicians and specialists, supports GPs and their role in chronic disease management, and reforms and modernizes laboratories.

The Agreement covers the period April 1, 2004 to March 31, 2007 and was reached through negotiation rather than the conciliation panel process. Compensation increases will be the subject of further negotiations with physicians in the third year of the agreement. The option of binding arbitration in the third year of the contract ensures it is consistent with the *Canada Health Act*.

Section 13 of the *Medicare Protection Act* provides that medical practitioners and dentists, who are enrolled under the Act and render benefits to a beneficiary of the Medical Services Plan (MSP), are eligible to be paid for services in accordance with the appropriate payment schedule. In 2003-2004, there were no amendments to section 13 of the *Medicare Protection Act*.

Payment for medical services delivered in the province is made through the MSP to individual physicians, based on submitted claims, and through the Alternative Payments Program (APP) to health authorities, also based on claims, for contracted physicians' services. The patient is not normally involved in the payment system. Ninety-nine point nine percent of MSP claims are submitted electronically through the Teleplan System, while the remainder are submitted on claim cards. Approximately 9.5 percent of physicians' compensation was distributed through the APP in 2003-2004.

The APP provides program-specific funding to British Columbia's six health authorities and the Nisga'a, which in turn, contract with physicians for their services or time through service contracts or sessional payments. Provincial agreements, negotiated as subsidiaries to the Master and Working agreements between the Government of British Columbia and BCMA, set the terms and conditions of physician compensation for government-funded services, including those funded by the APP. Approximately 2,292 physicians are supported, either wholly or in part, through APP funding arrangements.

5.5 Payments to Hospitals

In 2003-2004, the total payments to health authorities were $6.2 billion. These payments were for the provision of the full range of regionally delivered health care services which includes acute, residential, community care, public and preventive health, adult mental health and addictions programs. This does not include Medical Services Plan or other Ministry of Health Services' program payments to health authorities.

Payments to out-of-province hospitals within Canada for insured services (both in- and out-patient) provided to British Columbia residents totaled $56.4 million, while payment to hospitals outside the country totaled $2.7 million in 2003-2004.

6.0 Recognition

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of British Columbia through various government websites and provincial government documents. For the fiscal year 2003-2004, these documents included the following:

- ☐ Public Accounts 2003/04 (tabled June 29, 2004): **http://www.fin.gov.bc.ca/ocg/pa/03_04/PA_2004_all.pdf**
- ☐ Budget and Fiscal Plan, 2004/05 to 2006/07 (tabled February 17, 2004): **http://www.bcbudget.gov.bc.ca/bfp/default.htm**
- ☐ Estimates, Fiscal Year Ending March 31, 2005 (tabled February 17, 2004) **http://www.bcbudget.gov.bc.ca/est/25-26_Health_Services.html**

7.0 Extended Health Care Services (EHCS)

The Ministry of Health Services allocates funds to the health authorities to provide a comprehensive range of community-based supportive care services to assist people whose ability to function independently is affected by long-term health-related problems or who have acute care needs that can be met at home. Services include case management; in-home support services (home support, community home care nursing, physiotherapy, occupational therapy, nutrition counseling, social worker services and meals programs); assisted living; residential care services (family care homes, group homes and residential care facilities); community palliative care; residential hospice; and special support services (adult day centres, respite care and assessment and treatment centres). Services are delivered at the community level through the health authorities.

Residential care services provide 24-hour professional nursing care and supervision in a protective, supportive environment for adults who can no longer be looked after in their own homes.

Assisted living services provide a housing arrangement that consists of a private housing unit with a lockable door, hospitality services and personal care services.

Hospice services provide a residential home-like setting where supportive and professional care services are provided to British Columbians of any age who are in the end stages of a terminal illness or preparing for death. Services may include medical and nursing care, advance care planning, pain and symptom management, and psychosocial, spiritual and bereavement support.

A variety of housing alternatives are also available through health authorities for persons with mental illness and substance use disorders. Residential care facilities provide 24-hour care and intensive treatment services. Supported housing facilities provide stable and secure housing while residents receive treatment or community re-integration services in the community. In addition, persons with mental illnesses can reside and receive life-skills support in family care homes, which are private homes operated by families or individuals who are compensated for the services provided.

Home care nursing and community rehabilitation services are professional services, delivered to people of all ages in the community by registered nurses and rehabilitation therapists. These services are available on a non-emergency basis and include assessment, teaching and consultation, care coordination and direct care or treatment for clients with chronic, acute, palliative or rehabilitative needs.

Home support services provide assistance with activities of daily living and personal care. Adult day centres offer a centre-based program of health, social and recreational activities.

End-of-life care preserves clients' comfort, dignity and quality of life by relieving or controlling symptoms so those facing death, and the loved ones, can devote their energies to embracing the time they have together. Professional care givers and support staff provide supportive and compassionate care in the client's home, in hospital, hospice, an assisted living residence or a residential care facility.

A Palliative Care Benefits Program was implemented in 2001 to provide home-based palliative care clients with medication for pain and symptom relief and medical supplies and equipment, at no charge.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#).	3,785,150	3,804,133	3,981,617	4,019,744	4,084,463

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#): [1]					
a. acute care	94	94	94	92	92
b. chronic care	17	18	18	18	18
c. rehabilitative care	3	3	3	3	3
d. other	25	25	25	25	24
e. total	139	140	140	138	137
3. Payments ($): [2]					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004** [3]
4. Number (#):					
a. surgical facilities	1	1	1	1	11
b. diagnostic imaging facilities	not available	not available	not available	not available	0
c. total	1	1	1	1	11
5. Number of insured hospital services provided (#): [4]					
a. surgical facilities	810	634	689	612	not available [5]
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	810	634	689	612	not available
6. Payments ($):					
a. surgical facilities	558,000	348,700	353,100	358,600	1,470,370
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	558,000	348,700	353,100	358,600	1,470,370

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	4,277	4,359	4,430	4,471	4,573
b. specialists	3,268	3,297	3,380	3,421	3,510
c. other	0	0	0	0	0
d. total	7,545	7,656	7,810	7,892	8,083
8. Number of opted-out physicians (#):					
a. general practitioners	4	3	3	3	3
b. specialists	10	5	3	3	2
c. other	0	0	0	0	0
d. total	14	8	6	6	5
9. Number of not participating physicians (#):					
a. general practitioners	1	1	1	1	1
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	1	1	1	1	1
10. Number of services provided through fee for service (#):					
a. general practitioners	22,942,977	23,037,717	22,786,171	23,099,256	23,930,105
b. specialists	32,791,108	34,565,990	36,207,479	38,541,400	39,828,847
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	55,734,085	57,603,707	58,993,650	61,640,656	63,758,952
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	658,975,987	665,989,273	720,487,209	749,875,492	772,938,345
b. specialists	933,134,582	969,589,022	1,076,322,482	1,154,109,934	1,193,934,257
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,592,110,569	1,635,578,295	1,796,809,691	1,903,985,426	1,966,872,602
12. Average payment per fee for service service ($):					
a. general practitioners	28.72	28.91	31.62	32.46	32.30
b. specialists	28.46	28.05	29.73	29.94	29.98
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	28.57	28.39	30.46	30.89	30.85
13. Number of services provided through all payment methods (#): [6]					
a. medical	25,129,877	25,201,483	24,994,070	25,423,944	25,921,437
b. surgical	4,431,716	4,417,069	4,317,461	4,393,613	4,520,151
c. diagnostic	26,172,492	27,985,155	29,682,119	31,823,099	33,317,364
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	55,734,085	57,603,707	58,993,650	61,640,656	63,758,952
14. Total payments to physicians paid through all payment methods ($): [6]					
a. medical	928,286,068	942,736,513	1,025,581,421	1,068,441,470	1,093,491,339
b. surgical	250,524,151	252,828,480	279,710,272	296,852,610	307,627,814
c. diagnostic	413,300,350	440,013,302	491,517,998	538,691,346	565,753,449
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	1,592,110,569	1,635,578,295	1,796,809,691	1,903,985,426	1,966,872,602
15. Average payment per service, all payment methods ($): [6]					
a. medical	36.94	37.41	41.03	42.03	42.18
b. surgical	56.53	57.24	64.78	67.56	68.06
c. diagnostic	15.79	15.72	16.56	16.93	16.98
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. all services	28.57	28.39	30.46	30.89	30.85

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	7,231	8,113	8,113	7,618	7,294
17. Total number of claims, out-patient (#).	70,070	83,765	80,732	83,152	81,911
18. Total payments, in-patient ($).	34,477,406	35,882,521	40,898,996	40,195,515	45,318,174
19. Total payments, out-patient ($).	9,585,916	9,149,496	10,604,141	11,223,254	11,105,322
20. Average payment, in-patient ($).	4,768.00	4,422.84	5,041.17	5,276.39	6,213.08
21. Average payment, out-patient ($).	136.80	109.23	131.35	134.97	135.58
Physicians [7]	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	552,822	579,390	543,210	625,939	647,761
23. Total payments ($).	17,016,961	18,541,081	18,934,857	22,687,705	24,151,538
24. Average payment per service ($).	30.78	32.00	34.86	36.25	37.28

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	2,494	2,097	1,964	1,795	1,970
26. Total number of claims, out-patient (#).	324	720	637	949	611
27. Total payments, in-patient ($).	5,375,289	6,463,676	9,246,228	2,294,341	2,365,051
28. Total payments, out-patient ($).	65,137	134,789	119,928	543,969	294,712
29. Average payment, in-patient ($).	2,155.29	3,082.34	4,707.86	1,278.18	1,200.53
30. Average payment, out-patient ($).	201.04	187.21	188.27	573.20	482.34
Physicians [8]	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	77,424	77,973	71,940	71,377	57,093
32. Total payments ($).	3,485,618	3,281,934	3,013,045	3,083,949	2,458,027
33. Average payment per service ($).	45.02	42.09	41.88	43.21	43.05

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	272	283	275	249	243
35. Number of services provided (#).	54,638	55,643	43,505	36,680	36,809
36. Total payments ($).	5,893,820	6,321,864	5,401,691	5,379,450	5,164,249
37. Average payment per service ($).	107.87	113.61	124.16	146.66	140.30

Endnotes

For items 1-3: All data is preliminary for 2003-2004. Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year.

1. In British Columbia, the categories under which these facilities are reported in this Health Act report table do not match those normally used in the Ministry. For example, BC does not use the category 'chronic care facilities'.
   - For this table, the BC facilities have been assigned to the Health Act categories as closely as possible.
   - The 'Other' category is Diagnostic and Treatment Centres.
   - The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the *Societies Act* because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.
2. Payments to Health Authorities for the provision of the full range of regionally delivered services are as follows: $4.4 billion in 1999-2000, $5.1 billion in 2000-2001, $5.4 billion in 2001-2002, and $6.1 billion in 2002-2003. Payments to Health Authorities in 2003-2004, (base and one-time payments), was $6.2 billion.
3. Seven of these 11 contracts provide restorative dentistry to children who are clients of the Ministry of Human Resources. The remaining four are surgical contracts for the Fraser Health Authority.
4. There are approximately 49 private facilities licensed by the College of Physicians and Surgeons of British Columbia. These facilities provide mostly non-*Canada Health Act* services. Under the *Medicare Protection Act*, they are prohibited from extra-billing for any insured services. The numbers reported here reflect the number of private surgical facilities contracted with health authorities.
5. Data from the Provincial Health Services Authority contracts for the clients of the Ministry of Human Resources is 1,465. This figure reflects the number of patients served rather than the number of services provided. Data form the Fraser Health Authority is not available.
6. Data is available for "Fee-for-Service" only. Information is not available for the Alternative Payments Program.
7. The data summarizes the most current information about services and payments made each fiscal year based on the date of service.
8. The data summarizes the most current information about services and payments made each fiscal year based on the date of service.

Yukon

Introduction

The health care insurance plans operated by the Government of the Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The YHCIP is administered by the Director, as appointed by the Executive Council Member (Minister). The YHISP is administered by the Administrator, as appointed by the Commissioner in Executive Council (Commissioner of the Yukon Territory). The Director of the YHCIP and the Administrator of the YHISP are hereafter referred to as the Director, Insured Health and Hearing Services. References in this text to the "Plan" refer to either the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. There are no regional health boards in the Territory.

The objective of the Yukon health care system is to ensure access to, and portability of, insured physician and hospital services according to the provisions of the *Health Care Insurance Plan Act* and the *Hospital Insurance Services Act*. Coverage is provided to all eligible residents of the Yukon Territory on uniform terms and conditions. The Minister, Department of Health and Social Services, is responsible for the delivery of all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services. There were 30,917 eligible persons registered with the Yukon health care plan on March 31, 2004.

Other insured services provided to eligible Yukon residents include the Travel for Medical Treatment Program, Chronic Disease and Disability Benefits Program, Pharmacare and Extended Benefits Programs, and the Children's Drug and Optical Program. Non-insured health service programs include Continuing Care, Community Nursing, Community Health and Mental Health Services.

Health care initiatives in the Territory target areas such as access and availability of services, recruitment and retention of health care professionals, primary health care, systems development and alternative payment and service delivery systems, specifically:

☐ tele-health continues to expand and link patients and health care providers;

☐ primary care initiatives are proceeding that will broaden and strengthen service delivery and modernize and improve system capabilities; and

☐ physician recruitment and retention programs have been established that are funded by government and administered by the Yukon Medical Association.

The 2003-2004 health care expenditures increased over the 2002-2003 expenditures as follows:

☐ Insured Health Services increased by $3,208,000.

☐ Yukon Hospital Services increased by $2,317,000.

☐ Continuing Care increased by $394,000.

☐ Community Nursing and Emergency Medical Services increased by $279,000.

☐ Community Health Programs increased by $456,000.

Some of the major challenges facing the advancement of insured health care service delivery in the Territory are:

☐ effective linkages and co-ordination of existing services and service providers;

☐ recruitment and retention of qualified health care professionals;

☐ increasing costs related to service delivery;

☐ increasing costs related to changing demographics; and

☐ acquiring and maintaining new and advanced high-technology diagnostic and treatment equipment.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act* sections 3(2) and 4 establish the public authority to operate the health medical care plan. There were no amendments made to these sections of the legislation in 2003-2004.

The *Hospital Insurance Services Act* sections 3(1) and 5 establish the public authority to operate the health hospital care plan. There were no amendments made to these sections of the legislation in 2003-2004.

Subject to the *Health Care Insurance Plan Act*, (section 5) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

☐ develop and administer the Plan;
☐ determine eligibility for entitlement to insured health services;
☐ register persons in the Plan;
☐ make payments under the Plan, including the determination of eligibility and amounts;
☐ determine the amounts payable for insured health services outside the Yukon;
☐ establish advisory committees and appoint individuals to advise or assist in operating the Plan;
☐ conduct actions and negotiate settlements in the exercise of the Government of the Yukon's right of subrogation under this Act to the rights of insured persons;
☐ conduct surveys and research programs and obtain statistics for such purposes;
☐ establish what information is required under this Act and the form such information must take;
☐ appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and
☐ perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

Subject to the *Hospital Insurance Services Act* (section 6) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

☐ develop and administer the hospital insurance plan;
☐ determine eligibility for and entitlement to insured services;
☐ determine the amounts that may be paid for the cost of insured services provided to insured persons;
☐ enter into agreements on behalf of the Government of the Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
☐ approve hospitals for purposes of this Act;
☐ conduct surveys and research programs and obtain statistics for such purposes;
☐ appoint inspectors and auditors to examine and obtain information from hospital records, reports and accounts;
☐ prescribe the forms and records necessary to carry out the provisions of this Act; and
☐ perform such other functions and discharge such other duties as may be assigned by the Regulations.

1.2 Reporting Relationship

The Department of Health and Social Services is accountable to the Legislative Assembly and the Government of Yukon through the Minister.

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health and Hearing Services, make an annual report to the Executive Council Member respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the Legislature and is subject to discussion at that level.

The Statement of Revenue and Expenditures for the health care insurance programs of the Health Services Branch is tabled annually in the fall session of the Legislature. The report, to be tabled December 2004, covers the fiscal years 1998-1999 to 2003-2004.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Office of the Auditor General of Canada. The Auditor General of Canada is the auditor of the Government of the Yukon in accordance with section 30 of the *Yukon Act* (Canada). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of the Yukon. Further, the Auditor General of Canada is to report to the Yukon Legislative Assembly on any matter falling within the scope of the audit that, in his or her opinion, should be reported to the Assembly.

The most recent audit was for the year ended March 31, 2004.

Regarding the Yukon Hospital Corporation, section 11(2) of the *Hospital Act* requires every hospital to submit a report on the operations of the Corporation for that fiscal year. The report must include the financial statements of the Corporation and the auditor's report. The report is to be provided to the Department of Health and Social Services within six months of the end of each fiscal year.

1.4 Designated Agency

The YHCIP has no other designated agencies authorized to receive monies or to issue payments pursuant to the *Health Care Insurance Plan Act* or the *Hospital Insurance Services Act*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5 and 9, establish authority to provide insured hospital services to insured residents. There were no amendments made to these sections of the legislation in 2003-2004.

In 2003-2004, insured in-patient and out-patient hospital services were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one cottage hospital[1] and 12 Health Centres.[2] Additional visiting nursing services are provided from one satellite health station.[3]

Adopted on December 7, 1989, the *Hospital Act* establishes the responsibility of the Legislature and the Government to ensure "compliance with appropriate methods of operation and standards of facilities and care". Adopted on November 11, 1994, the Hospital Standards Regulation sets out the conditions under which all hospitals in the Territory are to operate. Section 4(1) provides for the Ministerial appointment of one or more investigators to report on the management and administration of a hospital. Section 4(2) requires that the hospital's Board of Trustees establishes and maintains a quality assurance program. Currently, the Yukon Hospital Corporation operates under a three-year accreditation through the Canadian Council on Health Services Accreditation.

The Yukon government assumed responsibility for operating Health Centres from the federal government in April 1997. These facilities, including the Watson Lake Cottage Hospital, operate in compliance with the adopted Medical Services Branch Scope of Practice for Community Health Nurses/Nursing Station Facility/Health Centre Treatment Facility, and the Community

---

[1] This facility provides 24-hour emergency treatment, short-term admissions and respite care.

[2] Community Nurse Practitioners, in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services.

[3] Community Nurse Practitioners provide itinerant services on a regularly scheduled basis.

Health Nurse Scope of Practice. The General Duty Nurse Scope of Practice was completed and implemented in February 2002.

Pursuant to the Hospital Insurance Services Regulations, sections 2(e) and (f), services provided in an approved hospital are insured. Section 2(e) defines in-patient insured services as all of the following services to in-patients, namely:

☐ accommodation and meals at the standard or public ward level;
☐ necessary nursing service;
☐ laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability;
☐ drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital;
☐ use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
☐ routine surgical supplies;
☐ use of radiotherapy facilities where available;
☐ use of physiotherapy facilities where available; and
☐ services rendered by persons who receive remuneration therefore from the hospital.

Section 2(f) of the same Regulations defines out-patient insured services as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident, namely:

☐ necessary nursing service;
☐ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury;
☐ drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital;
☐ use of operating room and anaesthetic facilities, including necessary equipment and supplies;
☐ routine surgical supplies;
☐ services rendered by persons who receive remuneration from the hospital;
☐ use of radiotherapy facilities where available; and
☐ use of physiotherapy facilities where available.

Pursuant to the Hospital Insurance Services Regulations, all in- and out-patient services provided in an approved hospital by hospital employees are insured services. Standard nursing care, pharmaceuticals, supplies, diagnostic and operating services are provided. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Department of Health and Social Services. This process is managed by the Director, Insured Health and Hearing Services. Public representation regarding changes in service levels is made through membership on the hospital board.

A new Yukon Computed Tomography Scan Program was implemented at the Whitehorse General Hospital in fall 2002. The Government provided $1.5 million toward purchasing a Computed Tomography (CT) scanner and picture archiving system. The program has been very successful and provides Yukon residents with local access to a standard diagnostic service.

These measures will help reduce the Territory's reliance on out-of-territory services.

2.2 Insured Physician Services

Sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 7,10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to these sections of the legislation in 2003-2004.

The YHCIP covers physicians providing medically required services. The conditions a physician must meet to participate in the YHCIP are to:

☐ register for licensure pursuant to the *Medical Professions Act*; and

☐ maintain licensure pursuant to the *Medical Professions Act*.

The estimated number of resident physicians participating in the YHCIP in 2003-2004 was 63.

Section 7(5) of the YHCIP Regulations allows physicians in the Territory to bill patients directly for insured services by giving notice in writing of this election. In 2003-2004, no physicians provided written notice of their election to collect fees other than from the YHCIP.

Insured physician services in the Yukon are defined as medically required services rendered by a medical practitioner. Services not insured by the Plan are listed in section 3 of the Regulations. Services not covered by the Plan include advice by telephone, medical-legal services, preparation of records and reports, services required by a third party, cosmetic services and services determined not to be medically required.

The process used to add a new fee to the relative Value Guide to Fees[4] is administered through a committee structure. This process requires physicians to submit requests in writing to the YHCIP/Yukon Medical Association Liaison Committee.

Following review by this committee, a decision is made to include or exclude the service. The relevant costs or fees are normally set in accordance with similar costs or fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. Public consultation is not required.

Alternatively, new fees can be implemented as a result of the fee negotiation process between the Yukon Medical Association and the Department of Health and Social Services. The Director, Insured Health and Hearing Services, manages this process and no public consultation is required.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Territory's health care insurance plan must be licensed pursuant to the *Dental Professions Act* and are given billing numbers for the purpose of billing the YHCIP for providing insured dental services. In 2003-2004, six dentists billed the Plan for insured dental services that were provided to Yukon residents. The Plan is also billed directly for services provided outside the Territory.

Dentists are able to opt out of the health care plan in the same manner as physicians. In 2003-2004, no dentists provided written notice of their election to collect fees other than from the YHCIP.

Insured dental services are limited to those surgical-dental procedures listed in Schedule B of the Regulations and require the unique capabilities of a hospital for their performance (e.g., surgical correction of prognathism or micrognathia).

The addition or deletion of new surgical-dental services to the list of insured services requires amendment by Order-in-Council to Schedule B of the Regulations Respecting Health Care Insurance Services. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia. The Director, Insured Health and Hearing Services, administers this process.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act* and Regulations and the *Hospital Insurance Services Act* and Regulations are insured. All other services are uninsured.

Uninsured physician services include:

☐ services that are not medically necessary;

☐ charges for longdistance telephone calls;

☐ preparing or providing a drug;

---

[4] Physician's fee guide manual.

☐ advice by telephone at the request of the insured person;
☐ medico-legal services including examinations and reports;
☐ cosmetic services;
☐ acupuncture; and
☐ experimental procedures.

Section 3 of the YHCIP Regulations contains a non-exhaustive list of services that are prescribed as non-insured.

Uninsured hospital services include:
☐ non-resident hospital stays;
☐ special/private nurses requested by the patient or family;
☐ additional charges for preferred accommodation unless prescribed by a physician;
☐ crutches and other such appliances;
☐ nursing home charges;
☐ televisions;
☐ telephones; and
☐ drugs and biologicals following discharge. (These services are not provided by the hospital.)

Uninsured dental services include:
☐ procedures considered to be restorative; and
☐ procedures that are not performed in a hospital under general anaesthesia.

Further, the Act states that any service that a person is eligible for, and entitled to, under any other Act is not insured.

All Yukon residents have equal access to services. Third parties such as private insurers or the Worker's Compensation Health and Safety Board do not receive priority access to services through additional payment.

The purchase of non-insured services, such as fibreglass casts, does not delay or prevent access to insured services at any time. Insured persons are given treatment options at the time of service.

The Territory has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services, to monitor usage and service concerns.

Physicians in the Territory may bill patients directly for non-insured services. Block fees are not used at this time; however, some do bill by service item. Billable services include, but are not limited to, completion of employment forms, medical legal reports, transferring records, third-party examinations, some elective services, and telephone prescriptions, advice or counseling. Payment does not affect patient access to services because not all physicians or clinics bill for these services and other agencies or employers may cover the cost.

The process used to de-insure services covered by the YHCIP is as follows:

☐ **Physician services** – the YHCIP/Yukon Medical Association Liaison Committee is responsible for reviewing changes to the Relative Value Guide to Fees, including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is not medically necessary, ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service, all physicians are notified in writing. The Director, Insured Health and Hearing Services, manages this process. No services were removed from the Relative Value Guide to Fees in fiscal year 2003-2004.
☐ **Hospital services** – an amendment by Order-In-Council to section 2 (e)(f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2004, no insured in-patient or out- patient hospital services, as provided for in the Regulations, have been de-insured. The Director, Insured Health and Hearing Services, is responsible for managing this process in conjunction with the Yukon Hospital Corporation.
☐ **Dental-surgical services** – an amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required. A service could be de-

insured if determined not to be medically necessary or is no longer required to be carried out in a hospital under general anaesthesia. The Director, Insured Health and Hearing Services, manages this process.

3.0 Universality

3.1 Eligibility

Eligibility requirements for insured health services are set out in the *Health Care Insurance Plan Act* and Regulations, sections 2 and 4 respectively and the *Hospital Insurance Services Act* and Regulations, sections 2 and 4 respectively. Subject to the provisions of these Acts and Regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and "means a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in the Yukon, but does not include a tourist, transient or visitor to the Yukon". Where applicable, the eligibility of all persons is administered in accordance with the Inter-provincial Agreement on Eligibility and Portability.

Under section 4(1) of both Regulations "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory".

Changes affecting eligibility made to the legislation in 2003-2004 now require that all persons returning to or establishing residency in Yukon complete the waiting period. The only exception is for children adopted by insured persons.

The following persons are not eligible for coverage in the Yukon:

☐ persons entitled to coverage from their home province or territory (e.g., students and workers covered under temporary absence provisions);
☐ visitors to the Territory;
☐ refugee claimants;
☐ members of the Canadian Forces;
☐ members of the Royal Canadian Mounted Police (RCMP);
☐ inmates in federal penitentiaries;
☐ study permit holders; and
☐ employment authorizations of less than one year.

The above persons may become eligible for coverage if they meet one or more of the following conditions:

☐ establish residency in the Territory;
☐ become a permanent resident;
☐ the day following discharge or release if stationed in or resident in the Territory.

3.2 Registration Requirements

Section 16 of the *Health Care Insurance Plan Act* states: "Every resident other than a dependant or a person exempted by the Regulations from so doing, shall register himself and his dependants with the Director, Insured Health and Hearing Services, at the place and in the manner and form and at the times prescribed by the Regulations." Registration is administered in accordance with the Inter-provincial Agreement on Eligibility and Portability.

Persons and dependants under the age of 19 who move permanently to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form available from the Insured Health and Hearing Services office or community Territorial Agents. Once coverage becomes effective, a health care card is issued. Family members receive separate health care cards and numbers. Health care cards expire every year on the resident's birthday and an updated label with the new expiry date is mailed out accordingly.

As of March 31, 2004, there were 30,917 residents registered with the YHCIP.

3.3 Other Categories of Individual

The YHCIP provides health care coverage for other categories of individuals as follows:

Returning Canadians	Waiting period is applied.
Permanent Residents[5]	Waiting period is applied.
Minister's Permit	Waiting period is applied if authorized.
Convention Refugees	Waiting period is applied if holding Employment Authorization.*
Foreign Workers	Waiting period is applied if holding Employment Authorization.*
Clergy	Waiting period is applied if holding Employment Authorization.*

* Employment Authorization must be in excess of 12 months

The estimated number of new individuals receiving coverage in 2003-2004 under the following conditions is:

Returning Canadians	19
Permanent Residents	32
Minister's Permit	0
Convention Refugees	0

The estimated number of individuals receiving coverage in 2003-2004, under the following conditions is:

Foreign Workers	22
Clergy	0

3.4 Premiums

The payment of premiums by Yukon residents was eliminated on April 1, 1988.

4.0 Portability

4.1 Minimum Waiting Period

Pursuant to section 4(1) of the YHCIP Regulations and the Yukon Hospital Insurance Services Regulations, "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory." All persons entitled to coverage are required to complete the minimum waiting period with the exception of children adopted from outside Canada by insured persons. (See section 3.1)

4.2 Coverage During Temporary Absences in Canada

The provisions relating to portability of health care insurance during temporary absences outside Yukon, but within Canada, are defined in sections 5, 6, 7 and 10 of the YHCIP Regulations and sections 6, 7(1), 7(2), and 9 of the Yukon Hospital Insurance Services Regulations. No amendments were made to these sections of the legislation in 2003-2004.

The Regulations state that "where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence". Persons leaving the Territory for a period exceeding two months are advised to contact the YHCIP and complete a form of "Temporary Absence". Failure to do so may result in the cancellation of coverage.

---

[5] Previously referred to as "landed immigrants".

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies. The Director, Insured Health and Hearing Services, may approve other absences in excess of 12 continuous months on receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

For temporary workers and missionaries, the Director, Insured Health and Hearing Services, may approve absences in excess of 12 continuous months on receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director, Insured Health and Hearing Services.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-provincial Agreement on Eligibility and Portability effective February 1, 2001. Definitions are consistent in Regulations, policies and procedures.

The Yukon participates fully with the Inter-provincial Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories except for Quebec, which does not participate in the medical reciprocal billing arrangement. Persons receiving medical (physician) services in Quebec may be required to pay directly and submit claims to the YHCIP for reimbursement.

The Hospital Reciprocal Billing Agreements provide for payment of insured in-patient and out-patient hospital services to eligible residents receiving insured services outside the Yukon, but within Canada.

The Medical Reciprocal Billing Agreements provide for payment of insured physician services on behalf of eligible residents receiving insured services outside the Yukon, but within Canada. Payment is made to the host province at the rates established by that province.

Insured services provided to Yukon residents while temporarily absent from the Territory are paid at the rates established by the host province. The following amounts were paid to out-of-territory hospitals for the fiscal year 2003-2004.

In-patient services	**Out-patient services**
$7,587,906	$936,376

Note: Figures are by date of service and subject to adjustment.

In 2003-2004, payments to out-of-territory physicians totaled $1,833,654. This figure includes out-of-Canada costs and is by payment date.[6]

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health care insurance to insured persons during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the YHCIP Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations. No amendments were made to these sections of the legislation in 2003-2004.

Sections 5 and 6 state that "Where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence".

Persons leaving the Territory for a period exceeding two months are advised to contact YHCIP and complete a form of "Temporary Absence". Failure to do so may result in the cancellation of coverage.

---

[6] Out-of-country costs are reported under elements 18 and 19 in the Yukon statistical tables.

The provisions for portability of health insurance during out-of-country absences for students, temporary workers and missionaries are the same as for absences within Canada (see section 4.2).

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in the Yukon. Reimbursement is made to the insured person by the YHCIP or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital. The standard ward rate for the Whitehorse General Hospital as of April 1, 2004, was $1,155, which increased July 1, 2004 to $1,246. This rate is established through Order-in-Council and are derived as follows:

☐ Standard Ward Rate = (total operating expenses - non-related in-patient costs - related newborn costs - associated out-patient costs) / (total patient days - patient days for other services; for example, non-Canadians).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Charges for Out-Patient Procedures Regulation. The out-patient rate is currently $153 and is established through Order-in-Council and derived by the Inter-provincial Health Insurance Agreements Coordinating Committee (IHIACC).

The following amounts were paid in 2003-2004 for elective and emergency services provided to eligible Yukon residents outside Canada:

In-patient services	Out-patient services
$13,563	$5,994

Note: Figures are by service date and subject to adjustment.

4.4 Prior Approval Requirement

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency hospital or physician services outside Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the YHCIP or the Yukon Hospital Insurance Services Plan. All services are provided on a uniform basis and are not impeded by financial or other barriers.

Access to hospital or physician services not available locally are provided through the Visiting Specialist Program, Telehealth Program or the Travel for Medical Treatment Program. These programs ensure that there is minimal or no delay in receiving medically necessary services.

There is no extra-billing in the Yukon for any services covered by the Plan.

5.2 Access to Insured Hospital Services

Pursuant to the *Hospital Act*, the "Legislature and Government have responsibility to ensure the availability of necessary hospital facilities and programs". The Minister must approve any significant changes to the level of service delivery. Acute care beds are readily available and no waitlist for admission exists at either of these two acute care facilities.

The estimated number of full-time equivalent (FTEs) nurses and other health care professionals working in facilities providing insured hospital services in the Yukon as of March 31, 2003, is:

Profession	**Whitehorse General Hospital** **# of FTEs**	**Watson Lake Cottage Hospital** **# of FTEs**
Registered Nurses	72	8
Licensed Practical	8	0
Nurse Pract.	0	0
Social Worker	1	0
Pharmacist	2	0
Physiotherapist	4.40	0
Occup. Therapist	1	0
Psychologist	0	0
Medical Lab/X-Ray	21	0
Dietician	3.5	0
Public Health	0	2
Home Care	0	1

The Whitehorse General Hospital and Community Nursing manage the supply of nurses and health care professionals in the Territory's two hospitals with the Department of Health and Social Services. Shortfalls in staffing are covered by temporary, casual or auxiliary workers to ensure residents have continued access to insured services.

Recruitment and Retention

Recruitment and retention initiatives include:

Community Nursing: A Yukon Advisory Committee on Nursing was struck to advise the Department of Health and Social Services on nursing issues. Recommendations will help the Yukon recruit and retain nurses in both the long and short term. Yukon is providing:

☐ competitive salaries;
☐ recruitment and retention bonuses;
☐ participation at job fairs;
☐ training and educational opportunities;
☐ travel bonus/$2,000 after one year; and
☐ relief positions.

Whitehorse General Hospital:

☐ competitive salaries;
☐ wage scale recognizes experience;
☐ cooperative work schedules;
☐ onsite fitness centre/24hour;
☐ monthly clinical skill development;
☐ continuing education/development; and
☐ travel bonus/$2,000 after one year.

Facilities

Whitehorse General Hospital: As the only major acute care hospital facility in the Territory, this facility provides in-patient, out-patient and 24-hour emergency services. Local physicians provide Emergency Department services on rotation.

Emergency surgery patients at the Whitehorse General Hospital are normally seen within 24 hours. Elective surgery patients are normally seen within one to two weeks. The number of Visiting Specialist clinics is routinely adjusted to address wait times, particularly for orthopaedics, ear/nose/throat and ophthalmology (see section 5.3).

Surgical services provided include:

☐ minor orthopaedics;
☐ selected major orthopaedics;
☐ gynecology;
☐ paediatrics;
☐ general abdominal;
☐ mastectomy;
☐ emergency trauma;
☐ ear/nose/throat/otolaryngology; and
☐ ophthalmology including cataracts.

Diagnostic services include:

☐ radiology (including ultrasound, computed tomography, xray and mammography;
☐ laboratory; and
☐ electrocardiogram.

Selected rehabilitative services are available through out-patient therapies.

Watson Lake Cottage Hospital: A second acute care facility is located in Watson Lake. Medical services include emergency trauma, maternity, minor orthopaedics, cellulitis, failure to thrive and respite care. Diagnostic services include x-ray, laboratory and electrocardiogram. This is a 12-bed facility and there is no waitlist for admission.

Health Centres: Out-patient and 24-hour emergency services are provided at the remaining 13 community Health Centres by Community Nurse Practitioners and auxiliary nursing staff.

Patients requiring insured hospital services not available locally are transferred to acute care facilities in-territory or out-of-territory through the Travel for Medical Treatment Program.

Measures to Improve Access

A number of measures have been taken to better manage access to insured hospital services. The Department of Health and Social Services continues to work with the Yukon Hospital Corporation and Community Nursing to ensure the current waiting time for insured hospital services in the Territory is reduced or maintained at existing levels. For example:

- ☐ Heart defibrillators were made available in all rural Yukon Health Centres. This provides an important tool to Community Nurse Practitioners and improves local access to cardiac care.
- ☐ Officials from the Department attend nursing recruitment fairs across Canada. Information on working in the Territory was provided to nurses who attended.
- ☐ The Technical Review Committee continues to make recommendations to the Department on health programs and services in the Yukon as required. Its mandate is to develop criteria initiating, eliminating, expanding or reducing programs or services.
- ☐ Telehealth in nine communities provides real-time video to support access and delivery of services between outlying rural communities with Whitehorse, and Whitehorse with outside centres in British Columbia or Alberta. Funding was provided through the Canada Health Infostructure Partnerships Program (CHIPP) to October 31, 2003.
  Telehealth educational sessions have occurred regularly between Whitehorse and rural Yukon as well as between Whitehorse and British Columbia. These sessions have been attended by patients, physicians, nurses, social workers, psychiatrists, mental health counsellors and allied professionals such as Community Health Representatives and First Nation Wellness workers.

5.3 Access to Insured Physician and Surgical-Dental Services

Existing legislation and administration of services provide all eligible Yukon residents with equal access to insured physician and dental services on uniform terms and conditions.

The following resident physicians, specialists and dentists provided services in the Yukon as of March 31, 2004 (see element #7 of the Yukon statistical tables):

General Practitioners/Family Practitioners	55
Specialists	8
Dentists	6

Outside the usual distribution of physicians and specialists in the Territory, uniform access to insured physician and dental services is ensured through the Travel for Medical Treatment Program. This program covers the cost of medically necessary transportation, allowing eligible persons to access services that are not available in their home communities. Eligible persons are routinely sent to Whitehorse, Vancouver, Edmonton or Calgary to receive services.

Most physicians in the Yukon are located in Whitehorse. Outside Whitehorse, only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. Two contracted physicians provide resident services in Faro and Mayo.

The Visiting Physician Program provides local access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians providing visiting services through this program are compensated under contract for lost practice time, mileage, meals and accommodation, in addition to a sessional rate or fee-for-service billings.

In addition, the Department of Health and Social Services and the Visiting Specialist Program provide local access at the Whitehorse General Hospital, Mental Health Services or the Yukon Communicable Disease Unit to non-resident, visiting specialist services not regularly available in the Territory. Visiting specialists are reimbursed for expenses in addition to a sessional rate or fee-for-service billings.

The number of specialists providing services under the Visiting Specialist Program and the Department of Health and Social Services is:

Ophthalmology	1
Oncology	3
Orthopaedics	3
Internal Medicine	1
Otolaryngology	2
Neurology	1
Rheumatology	1
Dermatology	1
Dental Surgery*	3
Infectious Disease*	1
Psychiatry*	3

* Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital.

Visiting Specialist clinics are held between one and eight times per year depending on demand and the availability of specialists. As of March 31, 2004, the waitlist for non-emergency specialist services was estimated at:

Ophthalmology	0-3 months
Orthopaedics	1-24 months
Otolaryngology	5-14 months
Neurology	4-10 months
Rheumatology	7-11 months
Dental Surgery*	2-3 months

* Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital.

Note: There is no waitlist for visiting services not included in the above listing. Patients are seen on the next scheduled visit (i.e., Oncology, Internal Medicine, Dermatology, Infectious Disease and Psychiatry).

The Department of Health and Social Services has taken several measures to reduce waiting times for insured physician services. A variety of recruitment and retention initiatives began in 2001-2002 and 2002-2003 such as a Resident Support Program, Locum Support Program, Physician Relocation Program, Office Start-Up Fund, Education Support and a Rural Training Fund. The Department of Health and Social Services continues to work with the Yukon Medical Association to find additional cooperative initiatives to be implemented within the terms of the renewed Memorandum of Understanding in April 1, 2004.

Amendments were made to the *Medical Professions Act* in 2002-2003 to provide for the issuance of special licenses in response to a demonstrated need. The candidate must have already been offered a position in the Territory subject to special licensing and the Minister of Health and Social Services must state in writing that a demonstrated need exists within an area of practice.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, before entering negotiations with the Yukon Medical Association (YMA). The YMA and the Government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The most recent four-year Memorandum of Understanding comes into effect April 1, 2004, and shall remain in effect to March 31, 2008. This MOU establishes the terms and conditions for payment of physicians and established two new programs: New Patient Program and Physician Retention Program.

The legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the Health Care Insurance Plan Regulations. No amendments were made to these sections of the legislation in 2003-2004.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. In 2003-2004, two full-time resident rural physicians and four resident specialists were compensated on a contractual basis. Two physicians providing visiting clinics in outlying communities were paid a sessional rate for services.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital) through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O and M) and capital funding levels are negotiated and adjusted based on operational requirements and utilization projections from prior years. In addition to the established O and M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

Only the Whitehorse General Hospital is funded directly through a contribution agreement. The Watson Lake Cottage Hospital and all Health Centres are funded through the Government of the Yukon's budget process.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act* and Regulations. The legislation and Regulations set out the legislative framework for payment to hospitals for insured services provided by that hospital to insured persons. No amendments were made to these sections of the legislation in 2003-2004.

6.0 Recognition Given to Federal Transfers

The Government of the Yukon has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its 2002-2003 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1)(d)(e) of the *Health Care Insurance Plan Act* and section 3 of the *Hospital Insurance Services Act*, acknowledge the contribution of the Government of Canada.

7.0 Extended Health Care Services

Residential Care Services

Continuing Care Health Services are available to eligible Yukon residents. In 2003-2004, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services:

☐ personal care;
☐ extended care services;
☐ nursing home intermediate care;
☐ special care;
☐ respite;
☐ day program; and
☐ meals on wheels.

A new continuing care facility was opened in Whitehorse in summer 2002 with 72 beds staffed and in operation. Twenty-four additional beds can be made available should future occupancy trends indicate a need.

In total, there was 113 continuing care or extended care beds in the Territory in 2003-2004.

No other major changes were made in the administration of these services in 2003-2004.

Home Care Services

The Yukon Home Care Program provides assessment and treatment, care management, personal support, homemaking services, social support, respite services and palliative care. In Whitehorse, services are provided by home support workers, nurses, social workers and therapists. In most rural communities, nursing services are provided through the community nursing program and home support workers assist clients with personal care, homemaking and respite services. Therapy services are provided by a travelling regional team of physiotherapists and occupational therapists. Services are available Monday through Friday. In Whitehorse, additional services such as planned weekend and evening support may be provided to 9:00 pm during end-stage palliative care. Twenty-four hour care is not provided.

Ambulatory Health Care Services

The Yukon Home Care Program provides the majority of ambulatory health care services outside institutional settings. Most other services are provided through Community Nursing or public health. All residents have equal access to services.

The above services are not provided for in legislation.

In addition to the services described above, the following are also available to eligible Yukon residents outside the requirements of the *Canada Health Act*:

☐ **The Chronic Disease and Disability Benefits Program** provides benefits for eligible Yukon residents who have specific chronic diseases or serious functional disabilities: coverage of related prescription drugs and medical-surgical supplies and equipment. (Chronic Disease and Disability Benefits Regulation)

☐ **The Pharmacare Program and Extended Benefits Programs** are designed to assist registered senior citizens with the cost of prescription drugs, dental care, eye care, hearing services and medical-surgical supplies and equipment. (Pharmacare Plan Regulation and Extended Health Care Plan Regulation)

☐ **The Travel for Medical Treatment Program** covers eligible Yukon residents for the cost of emergency and non-emergency medically necessary air and ground transportation to receive services not available locally. (Travel for Medical Treatment Act and Travel for Medical Treatment Regulation)

☐ **The Children's Drug and Optical Program** is designed to assist eligible low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 and younger. (Children's Drug and Optical Program Regulation)

☐ **Mental Health Services** provide assessment, diagnostic, individual and group treatment, consultation and referral services to individuals experiencing a range of mental health problems. (Mental Health Act and Mental Health Act Regulations)

☐ **Public Health** is designed to promote health and well-being throughout the Territory through a variety of preventive and education programs. This is a non legislated program.

☐ **Emergency Medical Services** is responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the nearest health care facility capable of providing the required level of care. This is a non legislated program.

☐ **Hearing Services** provides services designed to help people of all ages with a variety of hearing disorders, through the provision of routine and diagnostic hearing evaluations and community outreach. This is a non legislated program.

☐ **Dental Services** provides a comprehensive diagnostic, preventative and restorative dental service to children from pre school to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for pre school to grade twelve. This is a non legislated program.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#).	31,255	31,133	31,036	30,534	30,917

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#):					
a. acute care	2	2	2	2	2
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	13[1]	13[1]	13[1]	13[1]	13[1]
e. total	15	15	15	15	15
3. Payments ($):					
a. acute care	19,587,158	20,350,026	21,920,937	22,515,448	24,877,479
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	5,502,144[1]	5,483,948[1]	5,997,920[1]	6,133,453[1]	6,318,565[1]
e. total	25,089,302	25,833,974	27,918,907	28,648,901	31,196,044
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004 [2]
7. Number of participating physicians (#): [3]					
a. general practitioners	41	43	49	53	55
b. specialists	5	6	5	6	8
c. other	0	0	0	0	0
d. total	46	49	54	59	63
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	153,542	164,497	160,932	186,479	191,002
b. specialists	11,704	14,789	11,881	11,040	10,460
c. other	0	0	0	0	0
d. total	165,246	179,286	172,813	197,519	200,462
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	5,248,704	5,803,619	5,692,583	6,740,552	7,336,403
b. specialists	1,189,271	1,263,380	1,143,968	971,283	984,711
c. other	0	0	0	0	0
d. total	6,437,975	7,066,999	6,836,551	7,711,835	8,321,114
12. Average payment per fee for service service ($):					
a. general practitioners	34.18	35.28	35.38	36.15	38.61
b. specialists	101.61	85.43	96.29	87.98	94.14
c. other	0.00	0.00	0.00	0.00	0.00
d. all services	38.96	39.42	39.56	39.04	41.51
13. Number of services provided through all payment methods (#): [4]					
a. medical	123,333	131,685	131,004	154,591	151,825
b. surgical	22,092	25,670	26,653	26,388	31,894
c. diagnostic	19,822	18,978	15,156	16,540	16,472
d. other	0	0	0	0	0
e. total	165,247	176,333	172,813	197,519	200,461
14. Total payments to physicians paid through all payment methods ($): [4]					
a. medical	5,144,453	5,729,729	5,550,975	6,386,109	6,802,367
b. surgical	978,628	1,028,529	1,057,467	1,029,697	1,257,750
c. diagnostic	314,893	308,741	228,109	296,029	260,997
d. other	0	0	0	0	0
e. total	6,437,975	7,066,999	6,836,551	7,711,835	8,321,114
15. Average payment per service, all payment methods ($): [4]					
a. medical	41.71	43.51	42.38	41.31	44.80
b. surgical	44.30	40.07	39.68	39.02	39.44
c. diagnostic	15.89	16.27	15.05	17.90	15.04
d. other	0.00	0.00	0.00	0.00	0.00
e. all services	38.96	40.08	39.56	39.04	41.51

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	735	719	663	666	783
17. Total number of claims, out-patient (#).	7,025	6,760	6,547	7,241	6,938
18. Total payments, in-patient ($).	4,683,562	4,218,846	4,299,055	5,861,530	7,587,906
19. Total payments, out-patient ($).	920,769	861,375	945,804	1,037,692	936,376
20. Average payment, in-patient ($).	6,372.20	5,867.66	6,484.25	8,801.10	9,690.81
21. Average payment, out-patient ($).	131.07	127.43	144.47	143.31	134.96
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	31,020	36,828	32,461	34,853	34,037
23. Total payments ($).	1,404,195	1,642,495	1,601,642	1,799,019	1,833,654
24. Average payment per service ($).	45.27	44.60	49.34	51.62	53.87

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	11	9	15	9	8
26. Total number of claims, out-patient (#).	67	54	40	26	46
27. Total payments, in-patient ($).	22,125	27,520	50,599	9,339	13,536
28. Total payments, out-patient ($).	7,080	8,368	4,431	2,451	5,994
29. Average payment, in-patient ($).	2,011.37	3,057.78	3,373.27	1,037.67	1,692.00
30. Average payment, out-patient ($).	105.68	154.97	110.78	94.27	130.30
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	not available	not available	not available	not available	not available
32. Total payments ($).	not available	not available	not available	not available	not available
33. Average payment per service ($).	not available	not available	not available	not available	not available

Insured Surgical-Dental Services Within Own Province or Territory [5]

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	9	11	11	8	6
35. Number of services provided (#).	214	222	214	150	104
36. Total payments ($).	59,458	50,876	51,078	37,342	25,093
37. Average payment per service ($).	277.84	229.17	238.69	248.95	241.28

Insured Physician Services Within Own Province or Territory
Visiting Specialists, Locum Doctors and Member Reimbursements [6]

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
38. Number of services provided through fee for service (#):					
a. general practitioners	27,757	32,986	18,663	21,896	21,109
b. specialists	11,332	7,009	11,323	12,830	6,165
c. total	39,089	39,995	29,986	34,726	27,274
39. Total payments to physicians paid through fee for service ($):					
a. general practitioners	907,848	1,156,197	699,718	788,293	819,490
b. specialists	727,972	303,424	885,944	1,192,364	1,020,988
c. total	1,635,820	1,459,621	1,585,662	1,980,657	1,840,478
40. Average payment per fee for service service ($):					
a. general practitioners	32.71	35.05	37.50	36.00	38.82
b. specialists	64.24	43.29	78.25	92.94	165.61
c. total	41.85	36.50	52.88	57.04	67.48
41. Number of services provided through fee for service (#): [4]					
a. medical	31,609	31,099	23,431	25,402	23,466
b. surgical	5,141	6,121	4,888	7,510	2,097
c. diagnostic	2,339	2.775	1,667	1,814	1,711
d. total	39,089	39,995	29,986	34,726	27,274
42. Total payments to physicians paid through fee for service ($): [4]					
a. medical	1,436,115	1,133,717	1,224,899	1,392,766	1,371,373
b. surgical	132,349	260,188	285,503	481,940	374,435
c. diagnostic	67,356	65,716	75,261	105,951	94,671
d. total	1,635,820	1,459,621	1,585,663	1,980,657	1,840,479
43. Average payment per fee for service service ($): [4]					
a. medical	45.43	36.46	52.28	54.82	58.44
b. surgical	25.74	42.51	58.41	64.17	178.56
c. diagnostic	28.80	23.68	45.15	58.41	55.33
d. all services	41.85	36.50	52.88	57.04	67.48

Endnotes

1. Includes 12 health centres and one satellite health station.
2. Includes on-call payments to physicians.
3. Includes only resident family physicians and specialists.
4. Excludes services and costs provided by physicians under alternative payment agreements.
5. Includes direct billings for insured surgical-dental services received outside the territory.
6. Excludes services and costs provided by alternative payment agreements.

Northwest Territories

Introduction

The Northwest Territories (NWT) Department of Health and Social Services, together with eight Health and Social Services Authorities (HSSAs), plan, manage and deliver a full spectrum of community and facility-based services for health care and social services. Community health programs include daily sick clinics, public health clinics, home care, school health programs and educational programs. Physicians and specialists routinely visit communities without resident physicians. Services also include early intervention and support to families and children, mental health and addictions.

Boards of trustees for each HSSA provide NWT residents with the opportunity to shape priorities and service delivery for their communities. Nurses are the largest group of health care practitioners in the NWT.

As of April 1, 2004, there were an estimated 42,274 people in the NWT, of which half were Aboriginal people.[1] The NWT continues to have a relatively young population and a high birth rate. According to 2003 population estimates, approximately 25 percent of the NWT population was under 15 years of age, compared with 18 percent in the overall Canadian population.[2]

Maintaining a Sustainable System

In February 2002, the Minister of Health and Social Services released the *Health and Social Services System Action Plan 2002-2005*. This plan identifies 45 action items along with specific deliverables and timelines for improvements in the following areas:

- ☐ **Services to people** – actions to support people in taking care of themselves and to improve the support they receive from Health and Social Services (HSS);
- ☐ **Support to staff** – actions to attract and retain the wide range of HSS professionals who are essential to the delivery of high-quality services;
- ☐ **System-wide management** – actions to improve the organizational structure and management of the HSS System;
- ☐ **Support to trustees** – actions to fully develop the leadership role and capacities of the Boards of Trustees for HSS Authorities; and
- ☐ **System-wide accountability** – actions to clarify and increase accountability of the HSS System to the public, and the Department and HSS Authorities to the Minister, and with each other.

Public status reports have been issued every six months. Over the past two years, 39 action items have either been completed or become part of the ongoing work of the HSS System. Many Action Plan accomplishments created the foundation for delivering responsive, high-quality programming.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The NWT Health Care Plan includes the Medical Care Plan and the Hospital Insurance Plan. The public authority responsible for administering the Medical Care Plan is the Director of Medical Insurance as appointed under the *Medical Care Act*. The Minister administers the Hospital

---

[1] Statistics Canada, Quarterly Population Estimates and Statistics Canada, 2001 Census.

[2] Statistics Canada, CANSIM II, Table 051-0001, June 2003

Insurance Plan through Boards of Management established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act* (HIHSSA).

Legislation that enables the Plan in the NWT includes the *Medical Care Act* (revised 1988) and HIHSSA (revised 2003). In November 2003, minor amendments were made to the HIHSSA to allow the Minister to exempt employees of the Hay River Board from the public services, before reconstituting it as a Health and Social Services Authority under that Act rather than under the *Societies Act*.

The powers of the Minister are outlined in section15 of the HIHSSA. The Minister's mandate is further described in the Establishment Policy for the Department.

1.2 Reporting Relationship

In the NWT, the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for the administration of the *Medical Care Act* and the regulations. The Director reports to the Minister each fiscal year respecting the operation of the Medical Care Plan.

The Minister also appoints members to a Board of Management for each region in the NWT. Boards of Management are established under section 10 of the HIHSSA or under the *Societies Act*. The Boards are established with the authority to manage, control and operate health and service facilities and, subject to the *Financial Administration Act*, exercise any powers necessary and incidental to these duties. The Boards' chairpersons hold office indefinitely, while the remaining members typically hold office for a term of three years, for a maximum of three consecutive terms.

Pursuant to the *Financial Administration Act*, an annual audit of accounts is performed at each Board of Management. The Minister has regular meetings with Board of Management chairpersons. This forum allows the chairperson to provide non-financial reporting.

1.3 Audit of Accounts

The Hospital Insurance Plan and the Medical Care Plan are administered by the Department of Heath and Social Services. The Auditor General of Canada (AGC) has the mandate to audit the payments made under the Medical Care Plan. As part of the Public Accounts Audit, the AGC also audits the Hospital Insurance Plan.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and the Regulations. During 2003-2004, four hospitals and 28 health centres delivered insured hospital services to both in- and out-patients.

The NWT provides a full range of insured hospital services. Insured in-patient services include:

- ☐ accommodation and meals at the standard ward level;
- ☐ necessary nursing services;
- ☐ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
- ☐ drugs, biological and related preparations prescribed by a physician and administered in hospital;
- ☐ routine surgical supplies;
- ☐ use of operating room, case room and anaesthetic facilities;
- ☐ use of radiotherapy and physiotherapy services, where available;
- ☐ psychiatric and psychological services provided under an approved program; services rendered by persons who are paid by the hospital; and
- ☐ services rendered by an approved detoxification centre.

The NWT also provides a number of out-patient services. These include:

- ☐ laboratory tests, x-rays including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital;

- hospital services in connection with most minor medical and surgical procedures;
- physiotherapy, occupational therapy and speech therapy services in an approved hospital; and
- psychiatric and psychology services provided under an approved hospital program.

A detailed list of insured in- and out-patient services is contained in the Hospital Insurance Regulations. Section 1 of the Regulations states that "out-patient insured services" means the following services and supplies are provided to out-patients:

- laboratory, radiological and other diagnostic procedures together with the necessary interpretations for helping diagnose and treat any injury, illness or disability, but not including simple procedures such as examinations of blood and urine, which ordinarily form part of a physician's routine office examination of a patient;
- necessary nursing service;
- drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital;
- use of operating room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- services rendered by persons who receive remuneration for those services from a hospital;
- radiotherapy services within insured facilities; and
- physiotherapy services within insured facilities.

The Minister may add, change or delete insured hospital services. As such, the Minister recommends changes to the Regulations to the Commissioner. The Minister also determines if any public consultation will occur before making changes to the list of insured services.

Where insured services are not available in the NWT, NWT residents can receive them from hospitals in other jurisdictions. These services must be medically necessary. The NWT provides medical travel assistance, a supplementary health benefit program outlined in the Medical Travel Policy, which ensures that NWT residents have no barriers in accessing medically necessary services.

2.2 Insured Physician Services

The NWT *Medical Care Act* and the NWT Medical Care Regulations provide for insured physician services. All physicians and nurse practitioners must be licensed to practice in the NWT.

A wide range of medically necessary services is provided in the NWT. No limitation is applied if a service has been deemed an insured service. The Medical Care Plan insures all medically required procedures provided by medical practitioners, including:

- approved diagnostic and therapeutic services;
- necessary surgical services;
- complete obstetrical care;
- eye examinations; and
- visits to specialists, even when there is no referral by a family physician.

Following negotiations between the NWT Medical Association and the Director of Medical Insurance, additional medical services may be considered for inclusion in the fee schedule Regulation. It is the responsibility of the Director of Medical Insurance to manage the process of adding or deleting a medical service. However, it is the Minister who makes the determination to add or delete insured hospital services to the Regulations, as follows:

- establishing a medical care plan that provides insured services to insured persons by medical practitioners that will in all respects qualify and enable the NWT to receive payments of contributions from the Government of Canada under the *Canada Health Act*; and
- prescribing rates of fees and charges that may be paid in respect of insured services rendered by medical practitioners whether in or outside the NWT, and the conditions under which the fees and charges are payable.

2.3 Insured Surgical-Dental Services

Insured services and those related to oral surgery, injury to the jaw or disease of the mouth/jaw are eligible. Only oral surgeons may submit claims for billing. The NWT uses the Province of Alberta's Schedule of Oral and Maxillofacial Surgery Benefits as a guide.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided by hospitals, physicians and dentists, but not covered by the NWT Health Care Insurance Plan, include:

☐ medical-legal services;
☐ third-party examinations;
☐ services not medically required;
☐ group immunization;
☐ *in-vitro* fertilization;
☐ services provided by a doctor to his or her own family;
☐ advice or prescriptions given over the telephone;
☐ surgery for cosmetic purposes except where medically required;
☐ dental services other than those specifically defined for oral surgery;
☐ dressings, drugs, vaccines, biologicals and related materials administered in a physician's office;
☐ eyeglasses and special appliances;
☐ plaster and surgical appliances or special bandages;
☐ treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners as defined by the *Medical Care Act* and Regulations;
☐ physiotherapy and psychology services received from other than an insured out-patient facility;
☐ services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and
☐ routine annual checkups where there is no definable diagnosis.

In the NWT, prior approval applications must be made to the Director of Insured Services for uninsured medical goods or services provided in conjunction with an insured health service. A Medical Advisor is used to provide the Director with recommendations regarding the appropriateness of the request.

The NWT *Medical Care Act* includes Medical Care Regulations as well as the Physician Fee Schedule. This Act also provides for the authority to negotiate changes or deletions to the Physician Fee Schedule. The process was described in section 2.2 of this report.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* defines the eligibility of NWT residents to the NWT Health Care Insurance Plan.

The NWT uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the NWT Health Care Plan Registration Guidelines to define eligibility. There were no changes to eligibility for the reporting period.

Ineligible individuals for NWT health care coverage are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP), federal inmates and residents who have not completed the minimum waiting period.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation as applicable; e.g., visas and immigration papers. The applicant must be prepared to provide proof of residency if requested. Registration should optimally occur before the actual eligibility date of the client. Health care cards are renewed every two years. There is a direct link between registration and eligibility for coverage. Claims are not paid for clients who do not have valid registration.

As of August 2004, there were approximately 41,000 individuals registered with the NWT Health Care Plan. The registered number is from the NWT Department of Health and Social Services Health Care Plan registration database.

No formal provisions are in place for clients to opt out of the Health Care Insurance Plan.

3.3 Other Categories of Individual

Holders of employment visas, student visas and, in some cases, visitor visas are covered if they meet the provisions of the Eligibility and Portability Agreement and guidelines for health care plan coverage.

4.0 Portability

4.1 Minimum Waiting Period

There are waiting periods imposed on insured persons moving to the NWT. The waiting periods are consistent with the Interprovincial Agreement on Eligibility and Portability. Generally the waiting periods are the first day of the third month of residency, for those who move permanently to the NWT, or the first day of the thirteenth month for those with temporary employment of less than 12 months, but who can confirm that the employment period has been extended beyond the 12 months.

4.2 Coverage During Temporary Absences In Canada

The Interprovincial Agreement on Eligibility and Portability and the NWT Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the NWT for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the NWT for work, vacation, etc. Once an individual has completed a Temporary Absence form and been approved by the Department as being temporarily absent from the NWT, the full cost of insured services is paid for all services received in other jurisdictions.

The NWT participates in both the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The NWT Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada.

As per subsection 11. (1) (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. The NWT does provide personal reimbursement when an NWT resident leaves Canada for a temporary period for personal reasons such as vacations and requires medical attention during that time. Individuals will be required to cover their own costs and seek reimbursement upon their return to the NWT. The rates are the same as those contained in the Physician Fee Schedule and the hospital out- or in-patient rate.

Individuals may be granted coverage for up to a year (with prior approval), if they are outside the country. During the reporting period, no one was granted authorization to continue with his or her NWT health care coverage while remaining outside Canada for up to one year. In the eligibility rules, NWT residents may continue their coverage for up to one year if they are leaving Canada, but they must provide extensive information confirming that they are maintaining their permanent residence in the NWT. Because no one was covered by this clause, no payments were required. The rates are the same as those contained in the Fee Schedule for physicians and the hospital out- or in-patient rate.

4.4 Prior Approval Requirement

The NWT requires prior approval if coverage is to be considered for elective services in other provinces, territories and outside the country. Prior approval is also required if insured services are to be obtained from private facilities.

5.0 Accessibility

5.1 Access to Insured Health Services

The Medical Travel Supplementary Health Benefit Program ensures that economic barriers are reduced for all NWT residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed.

5.2 Access to Insured Hospital Services

Beds were available during the reporting period. If a bed shortage were to arise, the resident would be transported to another facility where appropriate beds exist. NWT hospitals and health centres continued to face some short-term staffing difficulties that had negative effects on their operations. However, through the use of medical travel arrangements, access to services was maintained throughout 2003-2004.

Facilities in the NWT do offer a range of medical, surgical, rehabilitative and diagnostic services. The NWT medical travel program ensures that residents will have access to necessary services not available in NWT facilities.

In order to improve access to insured hospital services, the NWT continued to expand the Telehealth program through technical upgrades to existing sites in 2003-2004. A number of steps were taken to ensure that installing equipment and upgrading the three existing WestNet sites (Inuvik, Fort Smith and Yellowknife) and adding four communities (Deline, Fort Simpson, Hay River and Holman) were completed.

In 2003, the Government of the Northwest Territories followed through with the previously announced investment of an additional $8.3 million into human resources within the HSS System. This investment builds on the Recruitment and Retention Plan for NWT Allied Health Professionals, Nurses and Social Workers (released in November 2002) to enhance professional development and educational opportunities, as well as employee supports.

5.3 Access to Insured Physician and Surgical-Dental Services

All NWT residents have access to all facilities operated by the Government of the Northwest Territories.

The medical travel program provides access to physicians for residents and the Telehealth program expands the specialist services available to residents in isolated communities.

5.4 Physician Compensation

The *Medical Care Act* and the Medical Care Regulations are used in the NWT to govern payments to physicians. To compensate physicians, the NWT uses two models: fee-for-service and employee contracts. The majority of family physicians are employed through a contractual arrangement with the NWT. The remainder provide services through a fee-for-service arrangement.

Physician compensation is determined for physician contracts and fees-for-service scheduled through negotiations between the NWT Medical Association and the Department. The Director of Medical Insurance and his or her designates negotiate on behalf of the Department. The NWT Medical Association chooses a negotiation team from within their membership. In March 2004, the NWT Fee Schedule was renewed along with new four-year General Practitioner and specialist contracts for the Stanton Territorial Heath Authority.

5.5 Payments to Hospitals

Payments made to hospitals are based on contribution agreements between the Boards of Management and the Department. Amounts allocated in the agreements are based on the resources available in the total government budget and level of services provided by the hospital.

Payments to facilities providing insured hospital services are governed under the HIHSSA and the *Financial Administration Act*. No amendments were implemented in 2003-2004 to provisions involving payments to facilities. A comprehensive budget is used to fund hospitals in the NWT.

6.0 Recognition Given to Federal Transfers

Federal funding received through the Canada Health and Social Transfer (CHST) has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents. For fiscal year 2003-2004, these documents included:

- ☐ 2003-2004 Budget Address;
- ☐ 2003-2004 Main Estimates;
- ☐ 2002-2003 Public Accounts; and
- ☐ 2003-2006 Business Plan for the Department of Finance.

The Estimates noted above represent the government's financial plan and are presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

Continuing Care programs and services offered in NWT communities may include: supported living, adult group homes, long-term care facilities and extended care facilities. These programs and services operate where applicable according to the Department of Health and Social Services Establishment Policy, the HIHSSA and the Hospital Standards Regulations.

Supported living services provide a home-like environment with increased assistance and a degree of supervision unavailable through home care services. Current services in this area include supported living arrangements in family homes, apartments and group-living homes, where clients live as independently as possible. Group homes, long-term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24-hour basis.

The NWT Home Care Program is a territorial-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the Regional Health and Social Services Authorities and include a broad range of services based on a multi-disciplinary assessment of individual needs. The Home Care Program provides services to the six regions of Yellowknife, Hay River, Fort Smith, Inuvik (inclusive of the Beaufort Delta and the Sahtu Region), Deh Cho and Dogrib.

Registered Persons

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#).	41,000	41,673	42,886 [1]	40,399 [1]	43,202 [1]

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#):					
a. acute care	4	4	4	4	4
b. chronic care	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]
c. rehabilitative care	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]
d. other	28 [3]	28 [3]	28 [3]	28 [3]	28 [3]
e. total	32	32	32	32	32
3. Payments ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]
c. rehabilitative care	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]	not applicable [2]
d. other	not available	not available	not available	not available	not available
e. total	36,215,847	40,282,046	44,268,039	48,451,358	50,962,729
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
6. Payments ($):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	35[4]	29[4]	24[4]	37[4]	44[4]
b. specialists	18[4]	18[4]	13[4]	16[4]	15[4]
c. other	106[5]	151[5]	175[5]	155[5]	169[5]
d. total	159[6]	198[6]	212[6]	208[6]	228[6]
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	142,004	81,921	32,339	18,493	20,671
b. specialists	9,487	5,466	5,618	5,524	5,240
c. other	not available	not available	not available	not available	not available
d. total	151,491	87,387	37,957	24,017	25,911
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	5,589,151	3,357,203	1,226,502	824,503	813,758
b. specialists	650,639	599,167	616,393	617,448	673,494
c. other	not available	not available	not available	not available	not available
d. total	6,239,790	3,956,370	1,842,895	1,441,951	1,487,252
12. Average payment per fee for service service ($):					
a. general practitioners	39.4	41.0	37.9	44.6	39.4
b. specialists	68.6	109.6	109.7	111.8	128.5
c. other	not available	not available	not available	not available	not available
d. all services	41.19	45.27	48.55	60.04	57.40
13. Number of services provided through all payment methods (#):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	213,665	200,198	199,751	195,508	197,543
14. Total payments to physicians paid through all payment methods ($):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	10,546,580	16,278,000	19,081,000	19,813,000	27,352,000
15. Average payment per service, all payment methods ($):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	49.36	81.31	95.52	101.34	138.46

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	1,076	952	992	1,233	1,015
17. Total number of claims, out-patient (#).	7,828	8,106	8,369	9,167	8,429
18. Total payments, in-patient ($).	7,124,045	5,235,249	5,688,458	8,606,767	6,100,096
19. Total payments, out-patient ($).	1,153,525	1,378,612	1,406,932	1,831,343	1,839,081
20. Average payment, in-patient ($).	6,620.86	5,499.21	5,734.33	6,980.35	6,009.95
21. Average payment, out-patient ($).	147.36	170.07	168.11	199.78	218.18
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	44,476	40,095	42,395	43,862	40,945
23. Total payments ($).	2,340,523	2,140,669	2,264,235	2,794,590	2,937,334
24. Average payment per service ($).	52.62	53.39	53.41	63.71	71.74

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	6	5	3	1	1
26. Total number of claims, out-patient (#).	12	16	15	51	18
27. Total payments, in-patient ($).	10,190	2,908	10,535	1,194	1,283
28. Total payments, out-patient ($).	2,270	1,713	2,181	99,009	16,763
29. Average payment, in-patient ($).	1,698.39	581.52	3,511.52	1,193.53	1,283.00
30. Average payment, out-patient ($).	189.20	107.04	145.39	1941.35	931.26
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	212	186	101	138	47
32. Total payments ($).	18,197	13,989	9,979	9,482	2,424
33. Average payment per service ($).	85.83	75.21	98.80	68.71	51.57

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	not available	not available	not available	not available	not available
35. Number of services provided (#).	not available	not available	not available	not available	not available
36. Total payments ($).	not available	not available	not available	not available	not available
37. Average payment per service ($).	not available	not available	not available	not available	not available

Endnotes

1. 2001-02 figure is as of September 18, 2002, 2002-03 figure is as of September 2, 2003, and the 2003-2004 figures is as of August 25, 2004.
2. Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the 4 hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.
3. Includes Health Centres and Public Health Units.
4. 1999/00 to 2001/02 numbers from Counts from Canadian Institute for Health Information, Southam Medical Database; and 2002/03 and 2003/04 numbers are estimates from NWT Department of Health and Social Services.
5. This is an estimate of the number of locum physicians. For measures 10 through 15, locum physicians are captured within the general practitioners and specialists categories.
6. Estimate based on total active physicians for each fiscal year.

Nunavut

Introduction

Nunavut was formed as a Territory on April 1,1999. The Territory covers one-fifth of Canada's total landmass. There are twenty-six communities situated across three time zones. The Territory is divided into three regions: the Qikiqtaaluk, which consists of 13 communities; the Kivalliq, which consists of eight communities; and the Kitikmeot, which consists of five communities. According to recent statistics, the population of Nunavut is 29,644. Approximately 40 percent of the population is under the age of 25. Inuit make up the majority at about 85 percent of the residents. There is a small French-speaking population of about four to six percent residing on Baffin Island, predominantly in the capital city of Iqaluit. Nunavut has a highly transient workforce, in particular skilled labourers and other seasonal workers from other provinces and territories.

Legislation governing the administration of health and social services in Nunavut was carried over from the Northwest Territories as Nunavut statutes pursuant to *Nunavut Act* (1999). Over the coming years, the Department of Health and Social Services plans to review all existing legislation to ensure its relevancy and appropriateness for the Government of Nunavut as set out in the objectives of The Bathurst Mandate Pinasuaqtavut. *Pinasuaqtavut* outlines the Government's agenda to achieve healthy communities, simplicity and unity, self-reliance and continuous learning. The incorporation of traditional Inuit values, known as Inuit Qaujimajatuqangit, in program policy development, service design and delivery, is an expectation placed on all departments.

The delivery of health services in Nunavut is based on a primary health care model. There is a local health centre in each of the 25 communities across Nunavut, as well as one regional hospital in Iqaluit. The primary health care providers are nurses with expanded scopes, with the exception of 17 full-time family physicians; 11 in the Qikiqtaaluk region; four in the Kivalliq region; two in the Kitikmeot region. Nunavut relies heavily on the Northern Medical Unit of the University of Manitoba, Ottawa Health Services Network Inc. and Stanton Regional Hospital in Yellowknife for the majority of its physician and specialist services.

The management and delivery of health services in Nunavut were integrated into the overall operations of the Department on March 31, 2000, when the former boards (Qikiqtaaluk, Kitikmeot and Kivalliq) were dissolved. Former board staff became employees of the Department at that time. The Department has a regional office in each of the three regions which manages the delivery of health services at a regional level. A continued emphasis on support to front-line service delivery has remained an integral part of this amalgamation.

The Territorial budget for health care and social services in 2003-2004 was $182,244,000 including approximately $28.8 million allocated for capital.

Nunavut's new *Nursing Act* (January 2004) allows for hiring nurse practitioners and over the next year amendments will be made to other legislation to outline the scope of the expanded responsibilities of these health care professionals.

In 2003-2004, Nunavut had 15 communities across the Territory connected to the Telehealth network. The Department of Health and Social Services received an additional $2.7 million from the Primary Health Care Transition Fund to allow for the addition of seven communities to the Telehealth network, to bring the total to 22 communities. These communities receive a broad range of services: specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counseling sessions; family visitation; and continuing medical education.

Nunavut has many unique needs and challenges with respect to the health and well-being of its residents. Approximately one-fifth of the Department's budget is spent on medical travel. Due to the very low population density in this vast territory and limited health infrastructure (equipment and health human resources), access to a range of hospital and specialist services often requires that residents be sent out of the Territory. A new regional hospital in Iqaluit and new regional health facilities in Rankin Inlet and Cambridge Bay that will be built over the next two years will enable Nunavut to build internal capacity and enhance the range of services that can be provided within the Territory. Nunavut continues to be challenged by the acute shortage of nurses, despite aggressive national and international recruitment and retention activities. Recruitment and retention of other health care professionals such as social workers, physicians and physiotherapists is also a challenge.

Nunavut received approximately $209,000 in 2003-2004 as part of a three year allotment of $4.4 million from the Primary Health Care Transition Fund Provincial/Territorial Envelope. These funds are designated to support the transitional costs of implementing sustainable, large-scale primary health care renewal initiatives. The Government of Nunavut has hired a Primary Health Care Renewal Implementation Coordinator and has plans for improvements to information technology, mental health training, health promotion, service provider training, Inuit staff capacity building, and population health programming.

Health promotion and prevention activities are high on the Department's list of service priorities. This includes strategies to reduce tobacco use, public education for healthy lifestyle choices, FASD awareness, importance of traditional foods, and pre-natal nutrition, and our Northern Contaminants Program.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans of Nunavut, including physician and hospital services, are administered by the Department of Health and Social Services on a non-profit basis.

The *Medical Care Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the Nunavut Act, 1999) enables the establishment of hospital and other health services.

Through the *Dissolution Act* (Nunavut, 1999), the three former Health and Social Services Boards of Baffin, Kitikmeot and Kivalliq were dissolved and their operations were integrated into the Department of Health and Social Services effective April 1, 2000. Regional sites were maintained to support front-line workers and community-based delivery of a wide range of health and social services.

There have been no legislative amendments for the fiscal year 2003-2004.

1.2 Reporting Relationship

A Director of Medical Care is appointed under the *Medical Care Act* and is responsible for the administration of the Territory's medical care insurance plan. The Director reports to the Minister of Health and Social Services and is required to submit an annual report on the operations of the medical insurance plan. Our annual submissions to the *Canada Health Act Annual Report* serve as the basis for these reports under the *Medical Care Act*.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General has the mandate to audit the activities of the Department of Health and Social Services.

The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government; however, the annual report was not tabled in the Legislature during 2003-2004.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided in Nunavut under the authority of the *Hospital Insurance and Health and Social Services Administration Act and Regulations*, sections 2 to 4. No amendments were made to legislation or Regulations in 2003-2004.

In 2003-2004, insured hospital services were delivered in 26 facilities throughout Nunavut, including a general hospital located in Iqaluit and 25 community health centres. The Baffin Regional Hospital in Iqaluit is the only acute care facility in Nunavut providing a range of in-patient and out-patient hospital services as defined by the *Canada Health Act*. Community health centres provide public health, out-patient services, emergency room services and some overnight services (observations). There are also a limited number of birthing beds at the Rankin Inlet Birthing Centre. Public health services are provided at a Public Health Clinic in Rankin Inlet and Iqaluit.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities and social services facilities in the Territory.

Insured in-patient hospital services include:

☐ accommodation and meals at the standard ward level;
☐ necessary nursing services;
☐ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
☐ drugs, biological and related preparations prescribed by a physician and administered in hospital;
☐ routine surgical supplies;
☐ use of operating room, case-room and anaesthetic facilities;
☐ use of radiotherapy and physiotherapy services, where available;
☐ psychiatric and psychological services provided under an approved program;
☐ services rendered by persons who are paid by the hospital; and
☐ services rendered by an approved detoxification centre.

Out-patient services include:

☐ laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital;
☐ hospital services in connection with most minor medical and surgical procedures;
☐ physiotherapy, occupational therapy, audiology and speech therapy services in an out-patient facility or in an approved hospital; and
☐ psychiatric and psychology services provided under an approved hospital program. The Department of Health and Social Services makes the determination to add insured services in its facilities based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Nunavut Financial Management Board.

No new services were added in 2003-2004 to the list of insured hospital services.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1), and Medical Care Regulations, section 3, provide for insured physician services in Nunavut. No amendments were made to legislation or Regulations in 2003-2004.

Although the *Nursing Act* (2004) allows for licensure of nurse practitioners in Nunavut, only medical doctors are permitted to deliver insured physician services in Nunavut at this time. The physician must be in good standing with a College of Physicians and Surgeons and be licensed to practice in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of 17 full-time family physicians in Nunavut (11 in the Qikiqtaaluk region; four in the Kivalliq region; two in the Kitikmeot region), as well as one surgeon at the Baffin Regional Hospital, providing services to Nunavummiut. Visiting specialists, general practitioners and locums, through arrangements made by each of the Department's three regions, also provide insured physician services. As of March 31, 2004, Nunavut had 139 physicians participating in the health insurance plan.

Physicians can make an election to collect fees other than those under the Medical Care Plan in accordance with section 12 (2)(a) or (b) of the *Medical Care Act* by notifying the Director in writing. An election can be revoked the first day of the following month after a letter to that effect is delivered to the Director. In 2003-2004, no physicians provided written notice of this election.

Insured physician services refers to all services rendered by medical practitioners that are medically required. Where the insured service is unavailable in Nunavut, the patient is referred to another jurisdiction to obtain the insured service.

The addition or deletion of insured physician services requires government approval. For this, the Director of Medical Insurance would become involved in negotiations with a collective group of physicians to discuss the service then the decision of the group would be presented to Cabinet for approval. No additions or deletions were added in 2003-2004.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan of the Territory must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999). Billing numbers are provided for the purpose of billing the Plan for the provision of insured dental services. In 2003-2004, five oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the Regulations, requiring the unique capabilities of a hospital for their performance, for example, of orthognathic surgery. Oral surgeons are brought to Nunavut on a regular basis but on rare occasions, for medically complicated situations, patients are flown out of Territory to more sophisticated centres.

The addition of new surgical-dental services to the list of insured services requires government approval; no new services were added to the list in 2003-2004.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided for under the *Workers Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) or other Acts of Canada, except the *Canada Health Act*, are excluded.

Services provided by physicians that are not insured include:

☐ yearly physicals;
☐ cosmetic surgery;
☐ services that are considered experimental;
☐ prescription drugs;
☐ physical examinations done at the request of a third party;
☐ optometric services;
☐ dental services other than specific procedures related to jaw injury or disease;

☐ the services of chiropractors, naturopaths, podiatrists, osteopaths and acupuncture treatments; and
☐ physiotherapy, speech therapy and psychology services, received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include:
☐ hospital charges above the standard ward rate for private or semi-private accommodation;
☐ services that are not medically required, such as cosmetic surgery;
☐ services that are considered experimental;
☐ ambulance charges (except inter-hospital transfers);
☐ dental services, other than specific procedures related to jaw injury or disease; and
☐ alcohol and drug rehabilitation, unless with prior approval.

The Baffin Regional Hospital charges $2,180.25 per diem for services provided for non-Canadian resident stays.

When residents are sent out of the Territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see section 4.2 under Portability). Any query or complaint is handled on an individual basis with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents in Nunavut. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton and Yellowknife), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services for Inuit and First Nations.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under section 3(1)(2)(3) of the *Medical Care Act*. The Department also adheres to the Inter-Provincial/Territorial Agreement on Eligibility and Portability as well as internal guidelines. No amendments were made to the legislation or Regulations in 2003-2004.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Territory, but does not include a tourist, transient or visitor to the Territory. Applications are accepted for health coverage and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number.

Coverage generally begins the first day of the third month after arrival in the Territory, but first-day coverage is provided under a number of circumstances, e.g. newborns whose mothers or fathers are eligible for coverage. As well, permanent residents (landed immigrants), returning Canadians, repatriated Canadians, returning permanent residents and a non-Canadian who has been issued an employment visa for a period of 12 months or more are also granted first-day coverage.

Members of the Canadian Armed Forces, the Royal Canadian Mounted Police and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, persons in Nunavut who are temporarily absent from their home province/territory and who are not establishing residency in Nunavut remain covered by their home provincial or territorial health insurance plans for up to one year.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. Nunavut will be going to a staggered renewal process in 2004-2005 as a new health claims system has been put into place in 2003-2004. No premiums exist. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. For non-residents, a valid health care card from their home province/territory is required.

As of March 31, 2004, 31,660 residents were registered with the Nunavut Health Care Plan. Nunavut's population statistics are published by Statistics Canada and include a number of temporary residents who are not eligible for coverage under the Territory's health plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers and individuals holding a Minister's Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis. This is consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration, which were adopted by Nunavut in 1999.

4.0 Portability

4.1 Minimum Waiting Period

Consistent with section 3 of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, the waiting period before coverage begins for individuals moving within Canada is three months or the first day of the third month following the establishment of residency in a new province or territory or the first day of the third month when an individual, who has been temporarily absent from his or her home province, decides to take up permanent residency in Nunavut.

4.2 Coverage During Temporary Absences In Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o), provide the authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents and the terms and conditions of payment. No legislative or regulatory changes were made in 2003-2004 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure coverage continues. Requests for extensions must be renewed yearly and are subject to approval by the Director. Temporary absences for work, vacation or other reasons for up to one year are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-

Provincial/Territorial Agreement on Eligibility and Portability, as of January 1, 2001.

Nunavut participates in Physician and Hospital Reciprocal Billing. Agreements are in place with other provinces and territories (Ontario, Manitoba, Alberta and the Northwest Territories).

The Hospital Reciprocal Billing Agreements provide payment of in-patient and out-patient hospital services to eligible Nunavut residents receiving insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Coordinating Committee on Reciprocal Billing. A special agreement exists between the Northwest Territories and Nunavut Territory which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (Western Arctic).

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

Out-of-territory hospitals were paid $18,755,064 in the fiscal year 2003-2004.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3), prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o), provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $1,396 per diem and $110 for out-patient care. No changes were made to these rates in 2003-2004.

In 2003-2004, Nunavut paid a total of $6,700 for insured emergency in-patient and out-patient health services to eligible residents temporarily outside Canada.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Territory. Reimbursement is made to the insured person or directly to the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services are also provided to patients in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital, located in Iqaluit, is the one acute care hospital facility in Nunavut. The hospital has 25 beds available for acute, rehabilitative, palliative and chronic care services. The hospital has a staff of 87, including 34 nurses and ten physicians. The facility provides in-patient, out-patient, and 24-hour emergency services. Local physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, intensive care services, respiratory services, cardiovascular care, maternity, palliative care, gastrointestinal bleeds and hypertension treatment. Surgical services provided include minor orthopaedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit.

Nunavut has special arrangements with facilities in Ottawa, Toronto, Churchill, Winnipeg, Edmonton and Yellowknife to provide insured services to referred patients.

Outside the Baffin Regional Hospital, out-patient and 24-hour emergency services are provided by all 25 health centres located in the communities.

Although nursing and other health professionals were not at the desired levels of staffing, all basic services were provided in 2003-2004. Nunavut is seeking to increase resources in all areas.

The use of Telehealth services has been a significant step in improving access to hospital, medical and other health and social services in Nunavut. Telehealth facilities are active in 15 communities with a goal of expanding to all other communities in 2004-2005. The long-term goal is to integrate Telehealth into the primary care delivery system, enabling residents of Nunavut greater access to a broader range of service options and allowing service providers and communities to use existing resources more effectively.

5.3 Access to Insured Physician and Surgical-Dental Services

In addition to the medical travel assistance and Telehealth initiatives, Nunavut has agreements with a number of health regions or facilities to provide medical and visiting specialists and other visiting health practitioner services. For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions. The Telehealth network, linking 15 communities, allows for the delivery of a broad range of services: specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions; family visitation; and continuing medical education. In 2003-2004, Nunavut had 139 physicians registered.

The following specialist services were provided under the visiting specialists program: ophthalmology, orthopaedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, paediatrics, obstetrics, physiotherapy, occupational therapy, psychiatry and dental surgery. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

There is one fee-for-service physician residing in Nunavut. Because fee-for-service physicians pay the expenses of running a practice in an isolated community, they are paid a rate 20 percent greater than the amounts set out in the schedule (per the *Medical Care Act*, section 4). The fees are negotiated between the Department of Health and Social Services and the physician, and are based on the NWT standards. The remaining physicians are on contract at a per-diem rate or are on salary. Visiting specialists are paid on a per diem basis under the terms of their contracts.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital and the 25 community health centres are part of the Department's budget as represented in the budgets for regional operations. No payments are made directly to hospitals or community health centres.

6.0 Recognition Given to Federal Transfers

Recognition will be given this year when the Director of Medical Care presents the 2002-2003 and 2003-2004 annual reports to the Minister.

7.0 Extended Health Care Services

The Home Care Program assists Nunavut residents who are not fully able to care for themselves at home. A community-based visiting service encourages self-sufficiency and supports family members and community involvement to enable individuals to remain safely in their own homes. Services include basic housekeeping support, meal preparation and assistance with daily living.

Intermediate care is available at St. Theresa's Home in Chesterfield Inlet. The facility provides 24-hour care and is fully staffed with professional and para-professional personnel. Nursing services are available between 7 a.m. and 7 p.m. After-hours services are for personal care only. The community health centre provides after-hours medical attention.

Nursing home services are available at the Iqaluit and Arviat's Elders Homes. These facilities provide the highest level of long-term care in Nunavut; that is, extensive chronic care services up to the point of acute care (levels 4 and 5) services. Acute care cases are transferred to the closest hospital.

Registered Persons	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
1. Number as of March 31st (#)	not available	26,829	28,630	29,478	31,660

Insured Hospital Services Within Own Province or Territory

Public Facilities	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
2. Number (#):					
a. acute care	1	1	1	1	1
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	25[1]	25[1]	25[1]	25[1]	25[1]
e. total	not available	not available	not available	not available	not available
3. Payments ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

1. Health Centres.

Insured Physician Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
7. Number of participating physicians (#):					
a. general practitioners	85	59	81	106	75
b. specialists	79	55	67	80	64
c. other	0	0	0	0	0
d. total	164	114	148	186	139
8. Number of opted-out physicians (#):					
a. general practitioners	not available	0	0	0	0
b. specialists	not available	0	0	0	0
c. other	not available	0	0	0	0
d. total	not available	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	not available	0	0	0	0
b. specialists	not available	0	0	0	0
c. other	not available	0	0	0	0
d. total	not available	0	0	0	0
10. Number of services provided through fee for service (#):					
a. general practitioners	not available	61,074	39,035	44,876	43,142
b. specialists	not available	29,485	19,733	20,656	17,419
c. other	not available	0	0	0	0
d. total	not available	90,559	58,768	65,532	60,561
11. Total payments to physicians paid through fee for service ($):					
a. general practitioners	2,323,234	2,494,221	1,943,399	2,137,218	2,023,584
b. specialists	1,146,522	1,229,811	1,042,366	1,199,648	1,524,873
c. other		0	0	0	0
d. total	3,469,756	3,724,032	2,985,765	3,336,866	3,548,457
12. Average payment per fee for service service ($):					
a. general practitioners	not available	40.83	49.79	47.62	48.16
b. specialists	not available	41.00	52.82	58.08	62.13
c. other	not available	0.00	0.00	0.00	0
d. all services	not available	40.92	50.81	50.92	53.31
13. Number of services provided through all payment methods (#):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
14. Total payments to physicians paid through all payment methods ($):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
15. Average payment per service, all payment methods ($):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	not available	not available	not available	not available	not available

Insured Services Provided to Residents in Another Province or Territory

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
16. Total number of claims, in-patient (#).	1,842	1,549	1,782	2,524	2,526
17. Total number of claims, out-patient (#).	9,656	8,682	9,155	10,677	12,112
18. Total payments, in-patient ($).	8,546,013	7,612,791	7,681,154	18,640,982	17,202,646
19. Total payments, out-patient ($).	1,470,018	1,352,594	1,525,710	1,740,038	1,552,418
20. Average payment, in-patient ($).	4,639.00	4,915.00	4,310.41	7,385.49	6,981.59
21. Average payment, out-patient ($).	152.00	156.00	166.65	162.00	138.47
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
22. Number of services (#).	not available	55,389	39,438	43,064	51,050
23. Total payments ($).	not available	3,232,940	2,335,998	2,674,445	2,955,996
24. Average payment per service ($).	not available	58.00	59.23	62.10	58.61

Insured Services Provided Outside Canada

Hospitals	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
25. Total number of claims, in-patient (#).	14	0	0	0	2
26. Total number of claims, out-patient (#).	5	1	53	3	2
27. Total payments, in-patient ($).	12,010	0	0	0	6,300
28. Total payments, out-patient ($).	1,130	110	128,398	982	400
29. Average payment, in-patient ($).	857.00	0.00	0.00	0.00	3,150.00
30. Average payment, out-patient ($).	226.00	110.00	2,422.60	327.28	200.00
Physicians	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**	**2003-2004**
31. Number of services (#).	0	0	12	1	19
32. Total payments ($).	0	0	14,835	8	1,519
33. Average payment per service ($).	0.00	0.00	1,236.25	7.61	151.91

Insured Surgical-Dental Services Within Own Province or Territory

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
34. Number of particpating dentists (#).	27	21	not available	not available	not available
35. Number of services provided (#).	not available	not available	not available	not available	not available
36. Total payments ($).	not available	not available	not available	not available	not available
37. Average payment per service ($).	not available	not available	not available	not available	not available

Annex A – Canada Health Act and Extra-Billing and User Charges Information Regulations

This annex provides the reader with an office consolidation of the *Canada Health Act* and the Extra-billing and User Charges Information Regulations. An "office consolidation" is a rendering of the original act, which includes any amendments that have been made since the Act's passage.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. These regulations are also presented in an office consolidation format.

This unofficial consolidation is current to June 2001.

CANADA

OFFICE CONSOLIDATION

Canada Health Act

R.S., 1985, c. C-6

Extra-billing and User Charges Information Regulations

SOR/86-259

June, 2001

CODIFICATION ADMINISTRATIVE

Loi canadienne sur la santé

L.R. (1985), ch. C-6

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

DORS/86-259

Juin 2001

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

CANADA

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Canada Health Act

Loi canadienne sur la santé

R.S., 1985, c. C-6

L.R. (1985), ch. C-6

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

Whereas the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

And whereas the Parliament of Canada wishes to encourage the development of health

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

services throughout Canada by assisting the provinces in meeting the costs thereof;

Now, therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution"
« contribution pécuniaire »

"cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist"
« dentiste »

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services"
« services complémentaires de santé »

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(*a*) nursing home intermediate care service,

(*b*) adult residential care service,

(*c*) home care service, and

(*d*) ambulatory health care service;

"extra-billing"
« surfacturation »

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan"
« régime d'assurance-santé »

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner"
« professionnel de la santé »

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital"
« hôpital »

"hospital" includes any facility or portion

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

TITRE ABRÉGÉ

1. *Loi canadienne sur la santé.*

Titre abrégé

1984, ch. 6, art. 1.

DÉFINITIONS

2. Les définitions qui suivent s'appliquent à la présente loi.

Définitions

« assuré » Habitant d'une province, à l'exception :

« assuré »
"insured person"

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la Loi sur le système correctionnel et la mise en liberté sous condition;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

« contribution » [Abrogée, 1995, ch. 17, art. 34]

« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé et de programmes sociaux qui peut être versée à une province au titre des paragraphes 15(1) et (4) de la Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces.

« contribution pécuniaire »
"cash contribution"

« dentiste » Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

« dentiste »
"dentist"

« frais modérateurs » Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

« frais modérateurs »
"user charge"

thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services"
« services hospitaliers »

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(*a*) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(*b*) nursing service,

(*c*) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(*d*) drugs, biologicals and related preparations when administered in the hospital,

(*e*) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(*f*) medical and surgical equipment and supplies,

(*g*) use of radiotherapy facilities,

(*h*) use of physiotherapy facilities, and

(*i*) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services"
« services de santé assurés »

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

« habitant »
"resident"

« habitant » Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

« hôpital »
"hospital"

« hôpital » Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

« loi de 1977 » [Abrogée, 1995, ch. 17, art. 34]

« médecin »
"medical practitioner"

« médecin » Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

« ministre »
"Minister"

« ministre » Le ministre de la Santé.

« professionnel de la santé »
"health care practitioner"

« professionnel de la santé » Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

« régime d'assurance-santé »
"health care insurance plan"

« régime d'assurance-santé » Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

« services complémentaires de santé »
"extended health care services"

« services complémentaires de santé » Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

« services de chirurgie dentaire »
"surgical-dental services"

« services de chirurgie dentaire » Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

"insured person"
« assuré »

"insured person" means, in relation to a province, a resident of the province other than

(*a*) a member of the Canadian Forces,

(*b*) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

(*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(*d*) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner"
« médecin »

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister"
« ministre »

"Minister" means the Minister of Health;

"physician services"
« services médicaux »

"physician services" means any medically required services rendered by medical practitioners;

"resident"
« habitant »

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services"
« services de chirurgie dentaire »

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge"
« frais modérateurs »

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c.8, s. 32; 1999, c. 26, s. 11.

« services de santé assurés »
"insured health services"

« services de santé assurés » Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

« services hospitaliers »
"hospital services"

« services hospitaliers » Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

« services médicaux »
"physician services"

« services médicaux » Services médicalement nécessaires fournis par un médecin.

« surfacturation »
"extra-billing"

« surfacturation » Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé.

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36.

CONTRIBUTION PÉCUNIAIRE

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé et de programmes sociaux (ci-après, Transfert).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36.

6. [Repealed, 1995, c. 17, s. 36]

6. [Abrogé, 1995, ch. 17, art. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility.

1984, c. 6, s. 7.

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité.

1984, ch. 6, art. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Définition de «services de santé assurés facultatifs»

(3) Pour l'application du paragraphe (2), « services de santé assurés facultatifs » s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11.

Accessibilité

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)c) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa a), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa b), sauf par une loi de la province.

1984, ch. 6, art. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre may reasonably require for the purposes of this Act; and

(*b*) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37.

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(*a*) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(*b*) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(*a*) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(*b*) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(*c*) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan

prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37.

MANQUEMENTS

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas

of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(*a*) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(*b*) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Entrée en vigueur du décret

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Nouvelle application des réductions ou retenues

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Application aux exercices ultérieurs

17. Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

EXTRA-BILLING AND USER CHARGES

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

SURFACTURATION ET FRAIS MODÉRATEURS

Surfacturation

18. Une province n’a droit, pour un exercice, à la pleine contribution pécuniaire visée à l’article 5 que si, aux termes de son régime d’assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l’égard des services de santé assurés qui ont fait l’objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

Frais modérateurs

19. (1) Une province n’a droit, pour un exercice, à la pleine contribution pécuniaire visée à l’article 5 que si, aux termes de son régime d’assurance-santé, elle ne permet pour cet exercice l’imposition d’aucuns frais modérateurs.

Réserve

(2) Le paragraphe (1) ne s’applique pas aux frais modérateurs imposés pour l’hébergement ou les repas fournis à une personne hospitalisée qui, de l’avis du médecin traitant, souffre d’une maladie chronique et séjourne de façon plus ou moins permanente à l’hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l’article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d’après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l’exercice ou, si les renseignements n’ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l’article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d’après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l’article 19 imposés dans la province pendant l’exercice ou, si les renseignements n’ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation de la province

(3) Avant d’estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(*a*) defining the services referred to in paragraphs (*a*) to (*d*) of the definition "extended health care services" in section 2;

(*b*) prescribing the services excluded from hospital services;

(*c*) prescribing the types of information that the Minister may require under paragraph 13(a) and the times at which and the manner in which that information shall be provided; and

(*d*) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13(b).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(a) or (b) except with the agreement of each of the provinces.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

RÈGLEMENTS

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a*) à *d*) de la définition de «services complémentaires de santé» à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13a) et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13b).

Consentement des provinces

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)a) ou b) qu'avec l'accord de chaque province.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(a) if they are substantially the same as regulations made under the Federal-Provincial Fiscal Arrangements Act, as it read immediately before April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(c) or (d) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40.

REPORT TO PARLIAMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

Exception

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)a) s'ils sont sensiblement comparables aux règlements pris en vertu de la Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces, dans sa version précédant immédiatement le 1er avril 1984.

Consultation des provinces

(4) Il ne peut être pris de règlements en vertu des alinéas (1)c) ou d) que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40.

RAPPORT AU PARLEMENT

Rapport annuel du ministre

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.

OFFICE CONSOLIDATION

Extra-billing and User Charges Information Regulations

SOR/86-259

CODIFICATION ADMINISTRATIVE

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

DORS/86-259

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(a) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH PROVINCE

SHORT TITLE

1. These Regulations may be cited as the Extra-billing and User Charges Information Regulations.

INTERPRETATION

2. In these Regulations.

"Act" means the *Canada Health Act*; (*Loi*)

"Minister" means the Minister of National Health and Welfare; (*ministre*)

"fiscal year" means the period beginning on April 1 in one year and ending on March 31 in the following year. (*exercice*)

TYPES OF INFORMATION

3. For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

4. For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13a) DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

1. Règlement concernant les renseignements sur la surfacturation et les frais modérateurs.

DÉFINITIONS

2. Les définitions qui suivent s'appliquent au présent règlement.

« exercice » La période commençant le 1er avril d'une année et se terminant le 31 mars de l'année suivante. (*fiscal year*)

« Loi » *La Loi canadienne sur la santé*. (*Act*)

« ministre » Le ministre de la Santé nationale et du Bien-être social. (*Minister*)

GENRE DE RENSEIGNEMENTS

3. Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4. Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

TIMES AND MANNER OF FILING INFORMATION

5. (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(*a*) in respect of the estimates referred to in paragraphs 3(*a*) and 4(*a*), before April 1 of the fiscal year to which they relate; and

(*b*) in respect of the financial statements referred to in paragraphs 3(*b*) and 4(*b*), before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3(*a*) and 4(*a*) before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

COMMUNICATION DE RENSEIGNEMENTS

5. (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3*a*) et 4*a*), avant le 1er avril de l'exercice visé par ces estimations;

b) pour les états financiers visés aux alinéas 3*b*) et 4*b*), avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3a) et 4a), avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

Annex B – Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/ territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995 to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the *Canada Health Act*, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

[Following is the text of the letter sent on June 18, 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, Federal Minister of Health and Welfare. (Note: Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.)]

June 18, 1985

OTTAWA, K1A 0K9

Dear Minister:

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the *Canada Health Act.* I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the *Canada Health Act*, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priorities of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role – both financial and otherwise – to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physical and mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the *Canada Health Act* does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the *Canada Health Act*, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

Public Administration

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

Comprehensiveness

The intent of the *Canada Health Act* is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

Universality

The intent of the *Canada Health Act* is to ensure that all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the *Canada Health Act*.

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the *Canada Health Act* does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bona-fide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the *Canada Health Act*.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the *Canada Health Act*. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting inter-provincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a co-ordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the *Canada Health Act* is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the *Canada Health Act* without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the *Canada Health Act* to their respective health care insurance plans. At the same time, I believe that all provincial/ territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

1. to make as few regulations as possible and only if absolutely necessary;
2. to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;
3. to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the *Canada Health Act*;
4. to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the *Canada Health Act* to expand, modify or change these broad- based data systems and exchanges. In order to keep information flows related to the *Canada Health Act* to an economical minimum, I see only two specific and essential information transfer mechanisms:

1. estimates and statements on extra-billing and user charges;
2. an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the *Canada Health Act*.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985-86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth [in this letter].

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the *Federal Post-Secondary Education and Health Contributions Act* (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the *Canada Health Act*. It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp

Attachments

[Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

> take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

☐ weakened public support for the tax funded and publicly administered system;
☐ the diminished ability of governments to control costs once they have shifted from the public to the private sector;
☐ the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
☐ the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system – resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal/Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

> "we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability."

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau

Minister of Health

Annex C – Dispute Avoidance and Resolution Process under the Canada Health Act

In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a Canada Health Act Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *Canada Health Act*, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

In September 2004, the agreement reached between the provinces and territories in 2002 was formalized by First Ministers, thereby reaffirming their commitment to use the CHA dispute avoidance and resolution process to deal with *Canada Health Act* interpretation issues.

On the following pages you will find the full text of Minister McLellan's letter to the Honourable Gary Mar, as well as a fact sheet on the Canada Health Act Dispute Avoidance and Resolution process.

Minister of Health Ministre de la Santé

Ottawa, Canada K1A 0K9

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act*.

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act*. This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has followed through on its September 2000 Health Agreement commitments by providing funding of $21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and health ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving *Canada Health Act* disputes in a fair and timely manner.

Yours sincerely,

A. Anne McLellan

Fact Sheet: Canada Health Act Dispute Avoidance and Resolution Process

Scope

The provisions described apply to the interpretation of the principles of the *Canada Health Act*.

Dispute Avoidance

To avoid and prevent disputes, governments will continue to:

- ☐ participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act issues*; and
- ☐ undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- ☐ collect and share all relevant facts;
- ☐ prepare a fact-finding report;
- ☐ negotiate to resolve the issue in dispute; and
- ☐ prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- ☐ Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who, together will select a chairperson.
- ☐ The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations.
- ☐ The panel will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

Review

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

Annex D – Documents Related to the Canadian Health Care System

The following is a listing of provincial and territorial documents and materials that relate to the five criteria of the *Canada Health Act* and to the recognition condition. These documents include annual reports of health care departments, financial documents relating to provincial and territorial health care, audit and evaluation reports and references to provincial and territorial legislation. Also included is some material that is national in scope.

Provincial/Territorial References to the Health Care System

Government of Newfoundland and Labrador

☐ Department of Health and Community Services. *Moving Forward Together: Mobilizing Primary Health Care.* (September 2003)
http://www.gov.nf.ca/health/publications/pdfiles/labhlth.pdf

☐ Department of Health and Community Services. *Operational Review of Health Labrador Corporation - Results of High Level Review - Final Report* (April 2003)
http://www.gov.nf.ca/health/publications/pdfiles/labhlth.pdf

☐ Department of Finance. *2004 Budget.* (March 30, 2004)
http://www.gov.nl.ca/budget2004/default.htm

☐ Newfoundland and Labrador Medical Association. *Arbitration Award Report - Government of Newfoundland and Labrador and Newfoundland and Labrador Medical Association.* (April 2003)
http://www.gov.nf.ca/publicat/2003/NLMAArbitration.pdf

☐ Office of the Auditor General. *Report of the Auditor General to the House of Assembly on Reviews of Departments and Crown Agencies for the fiscal year ended March 31, 2003.* (December 2003)
http://www.gov.nl.ca/ag/2003AnnualReport/AR2003.htm#ARTofC

☐ Legislation
http://www.gov.nf.ca/hoa/sr/body.htm

Government of Prince Edward Island

☐ Health and Social Services. *Annual Report 2002-2003.* (May 2004)
http://www.gov.pe.ca/photos/original/hss_e_ar_02-03.pdf

☐ Health and Social Services. *Schedule of Payments for Medical Services.*
http://www.gov.pe.ca/hss/medical/

☐ Office of the Auditor General. *2004 Report of the Auditor General to the Legislative Assembly.* (March 30, 2004)
http://www.gov.pe.ca/photos/original/ag_2004_report.pdf

☐ Provincial Treasury. *Budget Highlights 2004-2005 - Working Together for a Secure Tomorrow.* (March 30, 2004)
http://www.gov.pe.ca/budget/2004/highlights.pdf

☐ Provincial Treasury. *Estimates of Revenue and Expenditure 2004.* (March 30, 2004)
http://www.gov.pe.ca/budget/2004/estimates.pdf

☐ Provincial Treasury. *30th Annual Statistical Review, 2003.* (June 2004)
http://www.gov.pe.ca/photos/original/30annualreview.pdf

☐ Legislation
http://www.gov.pe.ca/law/statutes/index.php3

Government of Nova Scotia

☐ Department of Health. *Report of the Provincial Wait Time Monitoring Project Steering Committee.* (January 2004)
http://www.gov.ns.ca/health/wait_times/full-Wait%20Time.pdf

☐ Department of Health. *Backgrounder: Report of the Wait Time Monitoring Project Steering Committee.* (January 2004)
http://www.gov.ns.ca/health/wait_times/backgrounder-wait-times-report.pdf

☐ Department of Health. *Your Health Matters: Working Together Toward Better Care - An Update from the Department of Health.* (January 27, 2004)
http://www.gov.ns.ca/health/wait_times/wait-times-update.pdf

☐ Department of Health. *2003-2004 Business Plan.* (April 2003)
http://www.gov.ns.ca/health/downloads/2003-2004%20DoH%20Business%20Plan.pdf

☐ Department of Health. *Health Care Cost Drivers Fact Sheet.* (April 2004)
http://www.gov.ns.ca/health/downloads/Budget-Cost_Drivers.pdf

☐ Department of Health. *Minister's Report to Nova Scotians - Confident Change for Quality Care 2003-2004.* (March 2004)
http://www.gov.ns.ca/health/report/default.htm

☐ Department of Finance. *Budget Documents for the Fiscal Year 2004- 2005.* (April 2004)
http://www.gov.ns.ca/finance/budget04/default.asp

☐ Legislation:
http://www.gov.ns.ca/legi/lege/

Government of New Brunswick

☐ Department of Health and Wellness. *2002-2003 Annual Report.* (October 2003)
http://www.gnb.ca/0051/pub/pdf/2312-ef-final.pdf

☐ Department of Health and Wellness. *Budget 2004-2005 Backgrounder.* (June 2004)
http://www.gnb.ca/0051/budgets/pdf/Backgrounders2004-05-e.pdf

- ☐ Department of Health and Wellness. *Setting a New Direction for Planning the New Brunswick Physician Workforce.* (September 2003)
  http://www.gnb.ca/0051/pdf/HRStudy/SupplyandDemandAnalysis.pdf
- ☐ Department of Health and Wellness. *Reporting to New Brunswickers - The New Brunswick Health Care Report Card 2003.*
  http://www.gnb.ca/0051/pub/pdf/hrepcard-e.pdf
- ☐ Department of Health and Wellness. *Statutes Under the Jurisdiction of the Minister of Health and Wellness and Administered by the Department of Health and Wellness.* (May 31, 2004)
  http://www.gnb.ca/0062/deplinks/ENG/Haw.htm
- ☐ Department of Finance. *Budget 2004-2005, Living Within Our Means, Focusing on Priorities.* (March 30, 2004)
  http://www.gnb.ca/0160/budget/buddoc2004/bud2004-e.html
- ☐ Legislation:
  http://www.gnb.ca/0062/deplinks/ENG/Haw.htm

Government of Quebec

- ☐ Ministère de la Santé et des Services sociaux.[Department of Health and Social Services] *Rapport annuel de gestion 2002 - 2003.* (October 2003)
  http://www.msss.gouv.qc.ca/documentation/publications.html
- ☐ Ministère de la Santé et des Services sociaux. *Québec Public Health Program 2003-2012.* (February 12, 2004)
  http://ftp.msss.gouv.qc.ca/publications/acrobat/f/documentation/2003/03-2 16-02A.pdf
- ☐ Ministère de la Santé et des Services sociaux. *Politique d'Évaluation du Ministère de la Santé des Services sociaux - Évaluer pour s'améliorer.* (September 11, 2003)
  http://www.msss.gouv.qc.ca/documentation/publications.html
- ☐ Ministère des Finances. [Department of Finance] *2004-2005 Budget Speech.* (March 30, 2004)
  http://www.budget.finances.gouv.qc.ca/budget/2004-2005/en/pdf/BudgetSpeech.pdf
- ☐ Ministère des Finances. *2004-2005 Budget Highlights.* (March 30, 2004)
  http://www.budget.finances.gouv.qc.ca/budget/2004-2005/en/pdf/Highlight s.pdf
- ☐ Ministère des Finances, *2004-2005 Budget - Additional Information on the Budgetary Measures.* (March 30, 2004)
  http://www.budget.finances.gouv.qc.ca/budget/2004-2005/en/pdf/AdditionalInfoMeasures.pdf
- ☐ Vérificateur générale du Québec. [Auditor General of Quebec] *Report to the National Assembly for 2002-2003 - Volume II - Highlights.* (December 2004)
  http://www.vgq.gouv.qc.ca/publications/Rapp_2004_2/Highlights/Highlights.pdf
- ☐ Legislation
  http://www.justice.gouv.qc.ca/english/sites/lois-a.htm

Government of Ontario

☐ Ministry of Health and Long-term Care. *Ontario Health Insurance Plan - Fact Sheets and Q's and A's*
http://www.health.gov.on.ca/english/public/program/ohip/ohip_mn.html

☐ Ministry of Health and Long-term Care. *Commitment to Care: A Plan for Long-Term Care in Ontario* (Spring 2004)
http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohltc_rep04.html

☐ Ministry of Health and Long-term Care. *Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario.* (June 30, 2003)
http://www.health.gov.on.ca/english/public/pub/ministry_reports/nurseprac03/nurseprac03_mn.html

☐ Ministry of Finance. *2004 Ontario Budget: Budget Papers.* (May 2004)
http://www.gov.on.ca/FIN/bud04e/papers_all.htm

☐ Legislation
http://www.e-laws.gov.on.ca/home_E.asp?lang=en

Government of Manitoba

☐ Manitoba Health. *Annual Report and the Manitoba Health Services Insurance Plan, 2002-2003.* (November 2003)
http://www.gov.mb.ca/health/ann/200203/annrpt0203.pdf

☐ Manitoba Health. *Manitoba Health Annual Statistics 2002-2003.*
http://www.gov.mb.ca/health/annstats/index.html

☐ Manitoba Health. *Report on the Public Consultation and Review of The Personal Health Information Act.*
http://www.gov.mb.ca/health/phia/review.html

☐ Manitoba Health. *Manitoba Wait Time Reduction Plan.*
http://www.gov.mb.ca/health/waitlist/plan.html

☐ Manitoba Health. *Manitoba Infohealth Guide.*
http://www.gov.mb.ca/health/guide/index.html

☐ Manitoba Minister of Health. *Manitoba Physician's Manual.* (April 2004)
http://www.gov.mb.ca/health/documents/physmanual.pdf

☐ Manitoba Health. *Manitoba Nursing Strategy: Three Year Progress Report.* (March 2003)
http://www.gov.mb.ca/health/nurses/strategy.pdf

☐ Office of the Auditor General of Manitoba. *Review of the Symmetry Between the Accounting Principles of the Regional Health Authorities, Manitoba Health and the Province of Manitoba.* (May 2003)
http://www.oag.mb.ca/reports/reports_fr.htm

☐ Legislation
http://web2.gov.mb.ca/laws/statutes/index.php

Government of Saskatchewan

☐ Saskatchewan Health. *Its for Your Benefit - A Guide to Health Coverage in Saskatchewan.*
http://www.health.gov.sk.ca/mc_dp_skhealthbooklet.pdf

☐ Saskatchewan Health. *2003-04 Annual Report.*
http://www.health.gov.sk.ca/mc_dp_skhlth_2003-04_ar.pdf

☐ Saskatchewan Health. *Statistical supplement to the Annual Report of Saskatchewan Health, 2003-04.*
http://www.health.gov.sk.ca/mc_dp_msb_asr03_04.pdf

☐ Saskatchewan Health. *Global Health Indicators for Regional Health Authorities.* (July 2003)
http://www.health.gov.sk.ca/ph_ph_ere_ghi.pdf

☐ Saskatchewan Health. *The Action Plan for Saskatchewan Health Care – Progress Report.* (September 2003)
http://www.health.gov.sk.ca/hplan_action_plan_update.pdf

☐ Health Quality Council. *2003/04 Annual Report - Our Journey Continues*
http://www.hqc.sk.ca

☐ Office of the Provincial Auditor of Saskatchewan. *Saskatchewan 2003 Report Volume 3.* (December 2003)
www.auditor.sk.ca

☐ The Commission on Medicare (Fyke Commission). *Caring for Medicare: Sustaining a Quality System.*
http://www.health.gov.sk.ca/mc_dp_commission_on_medicare-bw.pdf

☐ Legislation
http://www.saskjustice.gov.sk.ca/legislation/acts.shtml

Government of Alberta

☐ Alberta Health and Wellness. *Alberta Ministry of Health and Wellness Annual Report 2003/2004.* (September 2004)
http://www.health.gov.ab.ca/resources/publications/AR03_04/index.html

☐ Alberta Health and Wellness. *Alberta Health Care Insurance Plan Statistical Supplement 2002/2003.* (September 2003)
http://www.health.gov.ab.ca/about/pdf/commitment.pdf

☐ Alberta Health and Wellness. *Alberta's commitment to public health care: understanding your public health care insurance plan, April 1, 2002 - March 31, 2003.* (December 2003)
http://www.health.gov.ab.ca/about/commitment.html

☐ Alberta Health and Wellness. *Health Costing in Alberta - 2003 Annual Report.* (August 2003)
http://www.health.gov.ab.ca/resources/publications/pdf/Health_Costing_2003.pdf

☐ Alberta Health and Wellness. *Master Agreement Regarding the Tri-lateral Relationship and Budget Management Process for Strategic Physician Agreements.* (February 2004)
http://www.health.gov.ab.ca/resources/publications/pdf/AHWtrilateralFinalJan04.pdf

☐ Alberta Finance. *Ministry of Health and Wellness Business Plan 2004-2007.* (March 24, 2004)
http://www.finance.gov.ab.ca/publications/budget/budget2004/health.html

☐ Legislation
Health Legislation
http://www.health.gov.ab.ca/about/minister/legislation.html
All Legislation
http://www.qp.gov.ab.ca/index.cfm

Government of British Columbia

☐ Ministry of Health Services. *2003-2004 Annual Service Plan Report.* (June 2004)
http://www.bcbudget.gov.bc.ca/annualreports/hs/hs.pdf

☐ Ministry of Health Services. *B.C. Surgical Wait Times Data.*
http://www.swl.hlth.gov.bc.ca/swl/

☐ Ministry of Health Services. British Columbia Medical Association. *Rural Programs 2002-04: A Guide for Rural Physician Programs in British Columbia.*
http://www.healthservices.gov.bc.ca/cpa/publications/rural_programs.pdf

☐ Ministry of Health Services. *Facts About Residential Care.*
http://www.healthservices.gov.bc.ca/hcc/pdf/factsrescare.pdf

☐ Ministry of Finance. *Budget 2003-2004.* (February 18, 2003)
http://www.bcbudget.gov.bc.ca/bgt2003/

☐ B.C. Guidelines and Protocols Advisory Committee. *Patient Information Guides.*
http://www.healthservices.gov.bc.ca/msp/protoguides/patguide.html

☐ Office of the Auditor General of British Columbia. *2003-04 Report 4: Alternative Payments to Physicians: A Program in Need of Change.* (November 2003)
http://bcauditor.com/AuditorGeneral.htm

☐ Legislation
http://www.qp.gov.bc.ca/statreg/

Government of the Yukon

☐ Yukon Medical Health Officer. *Yukon Health Status Report 2003.* (January 2004)
http://www.hss.gov.yk.ca/pdf/healthstatus03.pdf

☐ Department of Finance. *Budget 2003-2004.* (March 2003)
http://www.gov.yk.ca/pubs/2003/budgetspeech.pdf

☐ Yukon Executive Council Office - Bureau of Statistics. *Yukon Medical Doctor Exit Survey, 2003.* (December 2003)
http://www.gov.yk.ca/depts/eco/stats/onetime/yukonmed_doc_exit.pdf

☐ Department of Finance. *Public Accounts 2003-2004. Schedule of Expenditures by Department for the year ended March 31, 2004 - Health and Social Services.*
http://www.gov.yk.ca/depts/finance/publications/public_accounts/pub_acct s03-04/2003-04pub_s06.pdf

☐ Office of the Auditor General of Canada. *Report of the Auditor General of Canada to the Yukon Legislative Assembly for 2000 to 2003.* (June 2004)
http://www.oag-bvg.gc.ca/domino/reports.nsf/html/01nunavut_e.html/$file/200406yla_eng.pdf

- ☐ Legislation
  http://www.gov.yk.ca/legislation/

Government of the Northwest Territories

- ☐ Department of Health and Social Services (HSS) Publications: available at
  http://www.hlthss.gov.nt.ca/content/Publications/publication_index. htm
  - ☐ Integrated Service Delivery Model for the NWT Health and Social Services System. (March 2004)
  - ☐ Health and Social Services System Action Plan, 2002-2005.
  - ☐ Health and Social Services System Action Plan 2002-2005 - Status Report April - September 2003. (October 2003)
  - ☐ Community Wellness in Action Report 2002-2003. (November 2003)
  - ☐ New Public Health Legislation for the Northwest Territories - A Discussion Paper. (July 2003)
  - ☐ Seniors' Action Plan - Status Report. (June 2003)
- ☐ Office of the Auditor General of Canada. *Report of the Auditor General of Canada to the Northwest Territories Legislative Assembly, for the years ended March 31, 2000 and March 31, 2001.* (September 2002)
  http://www.oag-bvg.gc.ca/domino/reports.nsf/html/01nunavut_e.html/$file/200209nwtrpt_e.pdf
- ☐ Other documents, such as the Government's Business Plans, Main Estimates and Public Accounts, can be found on the Financial Management Board Secretariat Web site (see FMBS Library section) at:
  www.gov.nt.ca/FMBS
- ☐ Legislation
  http://www.justice.gov.nt.ca/Legislation/SearchLeg&Reg.htm

Government of Nunavut

- ☐ Department of Health and Social Services. *Business Plan 2003-2004.*
  http://www.gov.nu.ca/Nunavut/English/budget/2003/bp/hss.pdf
- ☐ Department of Finance. *Budget Address 2004.* (May 2004)
  http://www.gov.nu.ca/Nunavut/English/budget/2004address.pdf
- ☐ Department of Finance. *Main Estimates -Health and Social Services, 2003-2004.*
  http://www.gov.nu.ca/Nunavut/English/budget/2003/hss.pdf
- ☐ Office of the Auditor General of Canada. *Looking Back and Moving Forward: Auditor General of Canada's First Report to the Second Legislative Assembly of Nunavut, 2004*
  http://www.oag-bvg.gc.ca/domino/reports.nsf/html/01nunavut_e.html/$file/2004nla_eng.pdf
- ☐ Legislation
  http://www.nunavutcourtofjustice.ca/library/index.htm

National References to the Health Care System

☐ Commission on the Future of Health Care in Canada. *Final Report – Building on Values: The Future of Health Care in Canada* (November 2002)
http://www.hc-sc.gc.ca/english/care/romanow/index1.html

☐ Statistics Canada. *Health: Determinants; Resources and Use; Status*
http://www.statcan.ca/english/Pgdb/health.htm

☐ Canadian Institute for Health Information (CIHI).
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=reports_e#A

Analytic Reports: CIHI produces a range of analytical reports derived from its extensive information holdings and data analysis activities. Available by visiting the URL included above, reports include the following:

☐ *Average Payment per Physician Report – Canada 2002-2003* (December 2004)
☐ *Bringing the Future into Focus: Projecting RN Retirement in Canada* (July 2003)
☐ *From Perceived Surplus to Perceived Shortage: Canada's Physician Workforce* (June 2002)
☐ *Full-Time Equivalent Physicians (FTE) Report, Canada, 2001-2002* (December 2003)
☐ *Health Care in Canada, 2004* (June 2004)
☐ *Health Indicators, 2004* (June 2004)
☐ *Health Personnel Trends in Canada, 1993-2002* (April 2004)
☐ *Maclean's Health Report* (June 2003)
☐ *Medical Imaging in Canada* (September 2003)
☐ *National Grouping System Categories (NGS) Report, Canada, 2001-2002* (March 2004)
☐ *National Health Expenditure Trends, 1975-2003* (December 2003)
☐ *Reciprocal Billing (RB) Report, 2001/2002* (March 2004)
☐ *Supply, Distribution and Migration of Canadian Physicians 2003* (August 2004)
☐ *Workforce Trends of Licensed Practical Nurses in Canada, 2002* (October 2003)
☐ *Workforce Trends of Registered Nurses in Canada, 2002* (September 2003)

Western Canada Waiting List Project (WCWL)

Work on the objectives of WCWL_2 began in April 2002; these include implementation and evaluation of the waitlist management tools, development of standardized maximum acceptable waiting times linked to WCWL tool scores, and adaptation of the WCWL tools for use by primary care providers. Financial support for these projects is provided by Health Canada, Manitoba Health, Saskatchewan Health, Alberta Health & Wellness, and the British Columbia Ministry of Health Services. Newsletters:

http://www.wcwl.org/library/wcwl_newsletters/

Health Canada

☐ *Canada Health Act Annual Report, 2002-2003.*
http://www.hc-sc.gc.ca/medicare/Documents/CHA0203.pdf

☐ *Health Canada's response to the Auditor General's Report.* (November 1999)
http://www.hc-sc.gc.ca/english/media/releases/1999/agebk29.htm

☐ *Health Canada establishes Contribution Program to Improve Access to Health Services for Official Languages Minority Communities.* (February 23, 2004)
http://www.hc-sc.gc.ca/english/media/releases/2004/2004_07bk1.htm

☐ *Federal/Provincial/Territorial Ministers of Health establish new Canadian Patient Safety Institute.* (December 10, 2003)
http://www.hc-sc.gc.ca/english/media/releases/2003/2003_99.htm

☐ *Building a Better Tomorrow - Funding announced for a multi-jurisdictional primary health care initiative.* (November 27, 2003)
http://www.hc-sc.gc.ca/english/media/releases/2003/2003_91.htm

Other Federal Agencies

☐ Department of Justice. *Canada Health Act, Office Consolidation.*
http://laws.justice.gc.ca/en/C-6/index.html

☐ Madore, Odette. *The Canada Health Act: Overview and Options.* (June 2003) - Library of Parliament
http://www.parl.gc.ca/information/library/PRBpubs/944-e.htm

☐ Office of the Auditor General of Canada. F*ederal Support of Health Care Delivery.*
http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20020903ce.html

Annex E – Glossary of Terms Used in the Annual Report

The terms discribed in this glossary are defined within the context of the *Canada Health Act*. In other situations, these terms may have different definition or interpretation.

Term	Description
Accessibility	The accessibility criterion of the *Canada Health Act* (section 12) requires that health care insurance plans of provinces and territories provide: ☐ insured health care services on uniform terms and conditions, on a basis that does not impede or preclude reasonable access to these services by insured persons, either directly or indirectly; ☐ payment for insured health services according to a system of payment authorized by the law of the province or territory; ☐ reasonable compensation for all insured health care services rendered by physicians and dentists; and ☐ payment to hospitals to cover the cost of insured health care services.
Acute Care	Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.
Acute Care Facility	An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.
Admission	The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.
Block Fee	This is a fee charged by a physician for services that are not insured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.
Canada Health Act (CHA)	The *Canada Health Act* received Royal Assent on April 17, 1984, with the unanimous support of the House of Commons and the Senate. The Act, which replaced the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1968), sets out the national standards that the provincial and territorial health insurance plans must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST). The health portion of the CHST was replaced by the Canada Health Transfer effective April 1, 2004.

Term	Description
Canada Health and Social Transfer (CHST)	Coming into effect April 1, 1996, the Canada Health and Social Transfer (CHST) to provinces and territories provided support of health care, post-secondary education, social assistance and social services. The CHST replaced the Canada Assistance Plan, which cost-shared provincial and territorial social assistance programs. It also replaced the Established Programs Financing (EPF), which provided funding to support health care and post-secondary education. The CHST was composed of a tax transfer and a cash transfer. The tax transfer component went back to 1977 when, under EPF, the federal government agreed with provincial and territorial governments to reduce its personal and corporate income tax rates in all provinces while they increased their tax bases by an equivalent amount. As a result, revenue that would have flowed to the federal government began to flow directly to provincial and territorial governments. The CHST gave provinces and territories the flexibility to allocate payments among social programs according to their priorities, while upholding the principles of the CHA and the condition that there be no period of minimum residency with respect to social assistance.
Canada Health Transfer (CHT)	Effective April 1, 2004, the CHST was restructured into two new transfers, the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). The CHT supports the Government of Canada's ongoing commitment to maintain the national criteria and conditions of the *Canada Health Act*. The CST is a block fund in support of post-secondary education, social assistance and social services. It provides provinces and territories with the flexibility to allocate funds among social programs according to their respective priorities.
Chronic Care	Chronic care is care required by a person who is chronically ill or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable and who requires a range of services and medical management that can only be provided by a hospital.
Chronic Care Facility	A chronic care facility is a health care facility that provides ongoing, long-term, in-patient medical services. Chronic care facilities do not include nursing homes.
Comprehensiveness	A criterion of the *Canada Health Act* (section 9), which states that the health insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where provided by law in a province or territory, services rendered by other health care practitioners.
Consultation Process	Under Section 14(2) of the *Canada Health Act*, the Minister of Health must consult with a province or territory with respect to a potential breach of the five criteria and two conditions of the Act, before discretionary penalties can be levied for that province or territory.
Convention Refugee	A Convention refugee is a person who meets the definition of refugee in the *1951 United Nations Convention Relating to the Status of Refugees*. In general, it is someone who has left his or her home country and has a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group and is unable or, by reason of his or her fear, unwilling to seek the protection of the home country. In Canada, the Immigration and Refugee Board, Convention Refugee Determination Division, decides who is a Convention Refugee.

Term	Description
Coordinating Committee for Reciprocal Billing (CCRB)	Please see "Interprovincial Health Insurance Agreements Coordinating Committee."
Diagnostic Imaging	A procedure that detects or determines the presence of various diseases and/or conditions with the use of medical imaging equipment. Medical imaging equipment may include bone mineral densitometry, mammography, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, computed tomography (CT), and X-ray/fluoroscopy.
Diagnostic Physician Service	For purposes of reporting on the *Canada Health Act*, a diagnostic physician service is any medically required service rendered by a medical practitioner that detects or determines the presence of diseases or conditions.
Discretionary Penalties	Discretionary penalties are outlined in sections 14 to 17 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer (CHST) be made when a breach of any of the five criteria or two conditions of the *Canada Health Act* have been identified and could not otherwise be resolved through consultations between the respective levels of government. The amount of any deduction is based on the gravity of the default.
Dispute Avoidance and Resolution (DAR)	In April 2002, provincial and territorial governments accepted a *Canada Health Act* dispute avoidance and resolution (DAR) process that would apply to the interpretation of the principles of the *Canada Health Act* as outlined by the Honourable A. Anne McLellan, federal Minister of Health, in a letter to the Honourable Gary Mar, Alberta Minister of Health and Wellness. The *Canada Health Act* dispute avoidance and resolution process commits governments to continue to actively participate in ad-hoc federal, provincial and territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise. Health Canada will also continue to provide advance assessments on provincial and territorial measures and direction, when requested. Please see Annex C of this report for a more detailed description of the DAR process.
Eligibility and Portability Agreement	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by provincial and territorial Ministers of Health in 1971 and was implemented in 1972. The Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.
Enhanced Medical Goods and Services	These are medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.

Term	Description
Epp Letter	In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*. Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the *Canada Health Act*. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the *Canada Health Act*. The letter has been reproduced for reference purposes in Annex B of this report.
Established Programs Financing (EPF)	Introduced in 1977, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, also known as the *EPF Act*, replaced previous federal cost-sharing programs for insured hospital, medical and post-secondary transfers to provinces and territories. The EPF transfer was a block fund which increased annually on the basis of economic and population growth. Under the EPF, cash and tax transfers were provided to provinces and territories in support of health and post-secondary education. Tax transfers consisted of income tax points transferred by the federal government to provincial and territorial governments in 1977. In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion in EPF entitlement (cash plus tax), 71.2 percent of which was intended for health care and the rest for post-secondary education. The EPF transfer was replaced in 1996 by the Canada Health and Social Transfer.
Extended Health Care Services	Section 2 of the *Canada Health Act* defines extended health care services as nursing home intermediate care service; adult residential care service; home care service; and ambulatory health care service.
Extra-billing	Section 2 of the *Canada Health Act* defines extra-billing as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health insurance plan of a province or territory.
Extra-billing and User Charges Information Regulations	The only regulations in force under the *Canada Health Act* are the Extra-billing and User Charges Information Regulations, which require provincial and territorial governments to provide to the federal Minister of Health, prior to the beginning of a fiscal year, estimates of extra-billing and user charges that are permitted to exist under their health care insurance plans so that appropriate deductions to federal transfers can be levied. Provincial and territorial governments are also required under these Regulations to provide financial statements showing the amounts of extra-billing and user charges actually charged in a fiscal year so that reconciliations with previously estimated deductions can be applied. A copy of these regulations is provided in Annex A of this report.

Term	Description
Family-based Registration	A method for registering or enrolling persons under a health care insurance plan whereby insured persons are registered as family units.
Federal Policy on Private Clinics (Marleau Letter)	On January 6, 1995, federal Minister of Health Diane Marleau wrote to each of her provincial and territorial counterparts, providing them with the federal policy position and legal interpretation that the definition of "hospital" as set out in the *Canada Health Act* includes any facility providing acute, rehabilitative or chronic care and includes those health care facilities known as "clinics." She informed them that after October 15, 1995, it was her intention to interpret facility fees charged to patients in such facilities or clinics as user fees. Any province or territory not in compliance with the federal policy on private clinics faced mandatory penalties under the *Canada Health Act* calculated from October 15, 1995. These penalties take the form of deductions from monthly cash transfer payments under the Canada Health and Social Transfer. The Marleau Letter is included in Annex B of this report.
Fee-for-service	This is a method of payment for physicians based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate. Some services a general practitioner may provide are: consultation, diagnosis, reference, counselling, advice on health care and prevention of illness, minor surgeries, and prescribing medicines.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, dental care, physiotherapy) on an in-patient or out-patient basis to the public in general or to a designated group of persons or residents.
Health Care Insurance Plan	The *Canada Health Act* (section 2) defines a health care insurance plan as a plan or plans established by the law of a province or territory to provide for insured health services as defined under this same Act. (Please refer to definition of insured health services in this glossary.)
Health Insurance Supplementary Fund (HISF)	This is a fund, administered by the Canada Health Act Division to assist eligible individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the *Canada Health Act*. The fund was first established in 1972, when the portability of insurance between provinces varied and allowed for discrepancies in eligibility rules whereby a resident of Canada could become temporarily ineligible for health insurance in a province or territory following a change of province or a change of health care eligibility status (e.g., discharge from RCMP or Canadian Forces). The passage of the *Canada Health Act* in 1984 eliminated the discrepancies in interprovincial eligibility periods that were the source of most concerns for which the fund was established. There is currently $28,387 in the fund. There have been 5 applications for claims to the HISF since 1986; however, none of these have qualified under the terms and conditions for reimbursement.

Term	Description
Hospital	Section 2 of the *Canada Health Act* defines a hospital as any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include a hospital or institution primarily for the mentally disordered, or a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows for the reciprocal processing of out-of-province or out-of-territory claims for hospital in- and out-patient services from either jurisdiction. Under such an agreement, insured hospital services are payable at the approved rates of the host province or territory or as otherwise agreed upon by the parties involved or by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).
In-patient	This is a patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Insured Health Services	Under Section 2 of the *Canada Health Act*, insured health services means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any act of the legislature of a province that relates to workers' or workmen's compensation.
Insured Hospital Services	Under Section 2 of the *Canada Health Act* and the Federal Policy on Private Clinics, insured hospital services include any of the following services provided to in-patients or out-patients at a hospital or clinic if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely: ❑ accommodation and meals at the standard or public ward level and preferred accommodation if medically required; ❑ nursing service; ❑ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; ❑ drugs, biologicals and related preparations when administered in the hospital or clinic; ❑ use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; ❑ medical and surgical equipment and supplies; ❑ use of radiotherapy facilities; ❑ use of physiotherapy facilities; and ❑ services provided by persons who receive remuneration from the hospital or clinic.

Term	Description
Insured Person	An insured person is interpreted under the *Canada Health Act* as a resident of a province or territory other than ❑ a member of the Canadian Forces, ❑ a member of the Royal Canadian Mounted Police who is appointed to rank therein, ❑ a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or ❑ a resident of the province or territory who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province or territory for eligibility for or entitlement to insured health services.
Insured Physician Service	Please see "Physician Services."
Insured Surgical-Dental Service	Please see "Surgical-Dental Services."
Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC)	The Interprovincial Health Insurance Agreements Coordinating Committee, comprised of federal, provincial and territorial health department officials, was established in 1991 as the Coordinating Committee for Reciprocal Billing (CCRB), with the mandate to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services. The general intent of the provincial/territorial reciprocal billing agreements is to ensure that eligible Canadians have access to medically necessary health services when referred for these services outside their province or territory, when travelling or during educational leave or temporary employment. In 2002, the Committee changed its name to the Interprovincial Health Insurance Agreements Coordinating Committee to better reflect that the Committee's scope also extends to eligibility for health insurance coverage as well as interprovincial/territorial billing issues.
Mandatory Penalties	Provinces that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from federal transfer payments. Mandatory penalties are outlined in sections 20 to 21 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer (CHST) be made when a breach any of the extra-billing and user charges provisions of the *Canada Health Act* has been identified and could not otherwise be resolved through consultations between the respective levels of government.
Medical Necessity	Under the *Canada Health Act*, the provincial and territorial governments are required to provide medically necessary hospital and physician services to their residents on a prepaid basis, and on uniform terms and conditions. The Act does not define medical necessity. The provincial and territorial health insurance plans, in consultation with their respective physician colleges or groups, are primarily responsible for determining which services are medically necessary for health insurance purposes. If it is determined that a service is medically necessary, the full cost of the service must be covered by public health insurance to be in compliance with the Act. If a service is not considered to be medically required, the province or territory need not cover it through its health insurance plan.

Term	Description
Medical Practitioner	Section 2 of the *Canada Health Act* defines a medical practitioner as a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person.
Medical Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licenced physician to residents of the other jurisdiction. Where a reciprocal billing agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Non-Participating Physician	This is a physician operating completely outside provincial or territorial health insurance plans. Neither the physician nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health insurance plans. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.
Opted-out Physician	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at provincial or territorial fee schedule rates. The provincial or territorial plans reimburse patients of opted-out physicians for charges up to, but not more than the amount paid by the plan under fee schedule agreement.
Out-patient	This is a patient admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Diagnostic Care	Out-patient diagnostic care includes health care services in a health care facility for procedures that do not require an overnight stay and that detect and/or determine various diseases or health conditions.
Out-patient Surgical Facility	This is a health care facility providing short-term (day only) surgical services.
Participating Physician/Dentist	These are licensed physicians or dentists who are enrolled in provincial or territorial health insurance plans.
Physician Services	Section 2 of the *Canada Health Act* defines physician services as any medically required services rendered by medical practitioners.
Portability	This criterion of the *Canada Health Act* (section 11) requires that provincial and territorial health insurance plans not impose any minimum period of residence, or waiting period in excess of three months before residents become eligible for insured health services. In addition, the plans must cover and pay for insured services provided to insured persons while they are temporarily outside the province and during any period of residence, or waiting period imposed by the health care insurance plan of another province or territory.
Private Diagnostic Facility	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures.
Private (for-profit) Health Care Facility	This is a privately owned health care facility that pays out dividends or profits to its owners, shareholders, operators or members.

Term	Description
Private (not-for-profit) Health Care Facility	This is a privately owned health care facility that is recognized as operating on a non-profit basis under the laws of the provincial, territorial or federal governments.
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Provision of Information Condition	The *Canada Health Act* (section 13 (a)) requires that provincial and territorial governments provide information to the federal minister of health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of administering the Act.
Public Administration Criterion	The public administration criterion set out in section 8 of the *Canada Health Act* requires that each provincial and territorial health care insurance plan be administered and operated on a non-profit basis by a public authority that is responsible to the provincial or territorial government, and whose accounts and financial transactions are publicly audited.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides insured health care services under a provincial or territorial health care insurance plan on an in- or out-patient basis.
Recognition Condition	The *Canada Health Act* (section 13(b)) requires that provincial and territorial governments give recognition to the Canada Health and Social Transfer (CHST) in any public documents, advertisements or promotional material relating to insured health care services and extended health services in the province or territory.
Refugee Claimant	A refugee claimant is a person of non-Canadian nationality who has arrived in Canada and has applied for refugee protection status in Canada under the *Immigration and Refugee Protection Act*. If a refugee claimant receives a final determination from the Immigration and Refugee Board that he or she meets the definition of refugee in the 1951 *United Nations Convention Relating to the Status of Refugees*, then he or she may apply for permanent residence status in Canada.
Rehabilitative Care	Rehabilitative care includes health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. An example is therapy required by a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Resident	Section 2 of the *Canada Health Act* defines a resident as a person lawfully entitled to be or to remain in Canada who resides and is ordinarily present in the province or territory, but does not include a tourist, a transient or a visitor to the province or territory.

Term	Description
Specialist	A specialist is a licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures. Specialties include anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, ophthalmology, paediatrics, plastic surgery, radiology, and urology.
Surgery	The treatment of disease, injury or other types of ailment by using the hands or instruments to mend, remove or replace an organ, tissue, or part, or to remove foreign matter in the body.
Surgical-Dental Services	Section 2 of the *Canada Health Act* defines surgical-dental services as any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.
Surgical Physician Service	For purposes of reporting on the *Canada Health Act*, a surgical physician service is any medically required surgery rendered by a medical practitioner.
Temporarily Absent	Under the portability criterion of the *Canada Health Act* (section 11(1)(b)), the term "temporarily absent" is used to denote when a person is absent from their home province or territory of residence for reasons of business, education, vacation or other reasons, without taking up permanent residence in another province, territory or country.
Third-Party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges permitted under a provincial or territorial health care insurance plan for medical supplies and equipment such as alcohol swabs, instruments, sutures, etc., that are associated with the provision of an insured physician service.
Universality	This criterion of the *Canada Health Act* (section 10) requires that each provincial or territorial health care insurance plan entitle one hundred per cent of the insured persons of the province or territory to the insured health services provided for by the plan on uniform terms and conditions.
User Charge	Section 2 of the *Canada Health Act* defines a user charge as any charge for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health care insurance plan, but does not include any charge imposed by extra-billing. Please refer as well to the definition for extra-billing.

How to Contact Provincial and Territorial Departments of Health

Newfoundland and Labrador
Government Relations
Department of Health and Community Services
Confederation Building
P.O. Box 8700
St.John's, NL A1B 4J6
(709) 729-5305
www.gov.nl.ca/health

Prince Edward Island
Director, Corporate Services
Health and Social Services
P.O. Box 2000
Charlottetown, PE C1A 7N8
(902) 368-4929
www.gov.pe.ca/hss/

Nova Scotia
Senior Policy Analyst, Intergovernmental Affairs
Nova Scotia Department of Health
1690 Hollis Street
Halifax, NS B3J 2R8
(902) 424-5868
www.gov.ns.ca/health/

New Brunswick
Department of Health and Wellness
P.O. Box 5100
Fredericton, NB E3B 5G8
(506) 457-4800
www.gnb.ca/HW-SM/

Quebec
Department of Health and Social Services
1075 Sainte-Foy Road,
Québec, QC G1S 2M1
1-800-707-3380
www.msss.gouv.qc.ca
www.ramq.gouv.qc.ca/index_en.shtml

Ontario
Ministry of Health and Long-Term Care
Communications and Information Branch
Client Services
M1-57 MacDonald Block
900 Bay Street
Toronto, ON M7A 1N3
1-888-668-4636
www.gov.on.ca/health/

Manitoba
Client Services Centre
Manitoba Health
300 Carlton Street
Winnipeg, MB R3B 3M9
1-800-392-1207
www.gov.mb.ca/health

Saskatchewan
Saskatchewan Health
3475 Albert Street
Regina, SK S4S 6X6
1-800-6667-7766
www.health.gov.sk.ca

Alberta
Alberta Health Care Insurance Plan
P.O. Box 1360
Edmonton, AB T5J 2N3
(780) 427-1432
www.health.gov.ab.ca/ahcip/

British Columbia
Ministry of Health Services
P.O. Box 9050 Stn Prov Govt
Victoria, BC V8W 9E2
1-800-465-4911
www.gov.bc.ca/healthservices
hlth.health@gems1.gov.bc.ca

Yukon
Yukon Health Care Insurance
P.O. Box 2703
Whitehorse, YT Y1A 2C6
1-867-667-5209
www.hss.gov.yk.ca/

Northwest Territories
Health Services Administration
Department of Health and Social Services
Government of NWT
Bag Service # 9 Inuvik, NT X0E 0T0
1-800-661-0830 or 1-867-777-7413
www.hlthss.gov.nt.ca

Nunavut
Government of Nunavut
Department of Health and Social Services
P.O. Box 1000 Station 1000
Iqaluit, NU X0A 0H0
1-867-975-5700
www.gov.nu.ca/hss.htm